

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Ditto

04209

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Years

Hospital, institution, or street address where death occurred:

334 McDowell Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 334 McDowell Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

STILLWELL ELLSWORTH BARNHART

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Mary E. Dunn7. Birth date of deceased (mo., day, yr.) December 4, 18636. (c) If alive, give age 80 years8. AGE: Years 84 Months 4 Days 17 hrs. min.9. Birthplace Warfordsburg, Fulton Co. Pa.

(Town, county, and state)

10. Usual occupation Farmer11. Industry or business Retired12. Name Isaac Barnhart13. Birthplace Warfordsburg Pa.14. Maiden name Rebecca Truax15. Birthplace Warfordsburg Pa.16. Informant Mrs Lela KallfleshAddress Hagerstown Md.17. Burial Date thereof 4/23/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Dunkard CemeteryLocation Broadfording Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Apr 23 48 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 21, 1948 12:00N

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-1-48 to 4-21-48and that I last saw him alive on 4-21-48

Immediate cause of death

DURATION

Due to Chr. MyocarditisDue to General arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

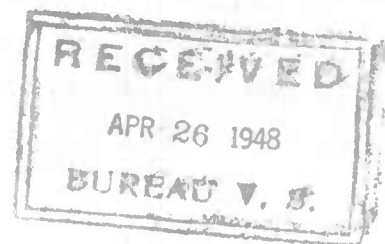
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Ditto M. D. or otherAddress Hagerstown Md. Date signed 4-24-48



Evidence for change of  
# 12 and # 15 shown on:

Reg. No. G 115 MAY 12 1948 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Yeager

04210

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 32 Years  
Hospital, institution, or street address where death occurred:  
52 E. Antietam St.  
How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 52 E. Antietam St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war None

3. (a) FULL NAME

RALPH CLEFTON BOND

3. (b) Social Security Number

705-10-4743

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Mary  
7. Birth date of deceased (mo., day, yr.) August 11, 1885  
6. (c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 62 Months 8 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Delta, York Co. Penna.  
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business Western Maryland R.R.

12. Name Edwina C. Bond

13. Birthplace Johnsville Md.

14. Maiden name Clara Smith

15. Birthplace SHIPPENSBURG, PENNA.

16. Informant Mrs Mary Bond

Address Hagerstown Md.

17. Burial Date thereof 4/22/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory New Oxford Cemetery

Location New Oxford, York Co. Penna.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Apr. 21 19 48 Charles H. Bowers  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19, 19 48 at 10:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 21, 19 28 to April 19, 19 48

and that I last saw him alive on April 19, 19 48

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Hypertensive Corded Vascular

Due to Acute Corded Failure 10 yrs.

Due to \_\_\_\_\_ 5 mos.

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. \_\_\_\_\_

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE C. Howard Yeager M. D. or other \_\_\_\_\_

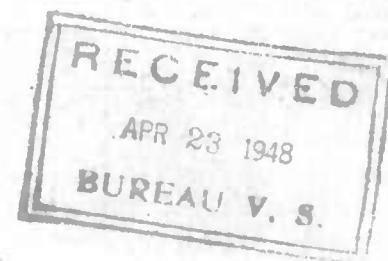
Address Hagerstown Md. Date signed April 20, 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



17  
M

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore 926  
CERTIFICATE OF DEATH

04211  
306  
Reg. Dist. No.

1. PLACE OF DEATH:  
County... Washington  
City or town... Ringgold  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 28 yrs. 20 days  
Hospital, institution, or street address where death occurred:  
  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State... Maryland County... Washington  
City or town... Ringgold  
(If outside city or town limits, write RURAL and give nearest town)  
Street No...  
(If rural, give LOCATION)  
2.(a) If veteran, name war...

3. (a) FULL NAME VIOLET VIRGINIA BOSWELL  
3. (b) Social Security Number 184-12-4728

4. Sex Female  
5. Color or race White  
6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife  
6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) March 31, 1920

8. AGE: Years 28 Months 0 Days 20 If less than one day  
hrs. min.

9. Birthplace... Ringgold, Maryland  
(Town, county, and state)

10. Usual occupation Secretary

11. Industry or business Smithsburg High Scholl

12. Name Harry W. Boswell

13. Birthplace Maryland

14. Maiden name Cora Miller

15. Birthplace Pennsylvania

16. Informant Harry W. Boswell  
Address Ringgold, Maryland

17. Burial Date thereof Apr. 24, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetary or crematory Ringgold Cemetery

Location Ringgold, Maryland

18. Funeral director R. J. Carnshaw

Address Keedysville, Md.

19. April 21, 1948 Geo. H. Ferguson  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... April 21, 1948 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1920 to April 21, 1948  
and that I last saw him alive on April 20, 1948

Immediate cause of death... Acute pulmonary edema 24 hrs.  
C.H.D. Double mitral 18 yrs.  
Rheumatic fever  
as a child.  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations...  
Date of op...

Autopsy results...  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Walter Henderson M.D.  
Address Waynesboro Va Date signed 4/21/48

RECEIVED

APR 26 1948

BUREAU V. 8

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04212

Reg. Dist. No. 302

1. PLACE OF DEATH: **Washington**  
 County.....  
 City or town..... **Rural Chewsville**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **80 years**  
 Hospital, institution, or street address where death occurred:  
**Hagerstown Rt. 1**  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State **Maryland** County **Washington**  
 City or town..... **Rural Chewsville**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **Hagerstown Rt. 1**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

**Annie Elizebeth Bovey**

## 3. (b) Social Security Number

-----

4. Sex **Female** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Widowed**  
 6. (b) Name of husband or wife **George Bovey**  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) **September 30, 1859**  
 8. AGE: Years **88** Months **6** Days **19** If less than one day..... hrs. .... min.

9. Birthplace **Lancaster Lancaster Co. Pa.**  
 (Town, county, and state)

10. Usual occupation **None**  
 11. Industry or business **None**

FATHER 12. Name **Christian Lowe**  
 13. Birthplace **Germany**

MOTHER 14. Maiden name **Mary Stahl**  
 15. Birthplace **Germany**

16. Informant **Mr. E. Frank Snyder**  
 Address **Hagerstown Rt. 1**

17. Burial **April 21, 1948**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory **Chewsville Cemetery**  
 Location **Chewsville Md.**

18. Funeral director **Scott F. Minniwh & Son**  
 Address **Hagerstown Md.**

19. **Apr. 20** 19 **48** **Blanch Powers**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH **April 19, 1948** at **12:05 P.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Mar 1** 19 **48** to **April 19** 19 **48**  
 and that I last saw him alive on **April 16** 19 **48**

Immediate cause of death **Cerebral Hemorrhage** DURATION **2 days**

Due to **arteriosclerosis** 20 yrs

Due to **generalized**

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

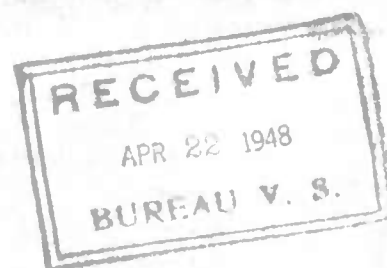
23. SIGNATURE **H. G. H. O'Brien** M. D. or otherAddress **San Antonio** Date signed **4/20/48**

MARGIN RESERVED FOR BINDING

VS A15 9:45:15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

APR 22 1948

BUREAU V. S.



# BIRTH AND DEATH

## MARYLAND STATE DEPARTMENT OF HEALTH

### CERTIFICATE OF STILLBIRTH

160a  
04213  
Reg. Dist. No. 303

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

#### 1. PLACE OF BIRTH:

County Washington  
 City or town HAGERS TOWN  
(If outside city or town limits, write RURAL and give nearest town)  
 Street address, hospital, or institution:  
Washington Co. Hospital  
 Length of mother's stay in County 24 hrs  
(How many years, or months, or days. SPECIFY WHICH)

#### 2. USUAL RESIDENCE OF MOTHER:

State PENN.  
 County CLARION  
 City or town SLIGO  
(If outside city or town limits, write RURAL and give nearest town)  
 Street No. BOX #2  
(If RURAL give LOCATION)

3. Name of child Baby COBBETT

5. Sex male 6. Twin or triplet single

4. Date of birth 4/20 1948 Hour 7:41 A.M.

7. No. of weeks pregnancy 28 WKS

#### FATHER OF CHILD

8. Full name JACK W. WYMAN  
 9. Color wh 10. Age at time of this birth 26 yrs.  
 11. Usual occupation TRUCKING

#### MOTHER OF CHILD

12. Full maiden name MARION COBBETT  
 13. Color W. 14. Age at time of this birth 19 yrs.  
 15. Usual occupation HOUSEWORK

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0  
 (b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 1

17. Did child die before labor? NO During labor? NO

18. Pregnancy, complications of none

19. Labor: (a) Complications of none  
 (b) Induced? —

20. (a) Was there an operation for delivery? NO  
 (b) State all operations, if any. — (Yes or No)

(c) Did child die before operation? —  
 During operation? —

21. ~~Cause of stillbirth.~~ Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Prematurity and central hemorrhage.  
 (b) Maternal causes Retroploental hemorrhage.

22. I certify to the birth of this child who was born dead\* on the date and hour above stated.

Signature M. J. Seelicher MD  
(Specify if M. D., midwife, or other)

Address Hagerstown Maryland

23. (a) Burial (b) Date thereof 4/21/48  
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Rose Hill Cemetery

24. (a) Funeral director Andrew K. Coffman

(b) Address Hagerstown Md.

25. (a) Apr. 21, 1948 (b) Frank Bowser  
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)  
 The above certificate has been examined by me.

Health Officer, per.....

\* See Instruction C on stub.

child lived 2 hours

RECEIVED

APR 23 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04214 302

### 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred:  
Lincoln Avenue.  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland. County Washington  
City or town Hagerstown, Maryland.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1094 Murdock Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Howell G. Dixon

### 3. (b) Social Security Number

705-10-7447

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Anna M. Dixon

7. Birth date of deceased (mo., day, yr.) February 14, 1889 6.(c) If alive, give age ..... years

8. AGE: Years 59 Months 2 Days 9 If less than one day ..... hrs. .... min.

9. Birthplace Keedysville, Wash. Co. Md.  
(Town, county, and state)

10. Usual occupation Welder

11. Industry or business

FATHER 12. Name William Dixon  
13. Birthplace Keedysville, Md.

MOTHER 14. Maiden name Emma Miller  
15. Birthplace Keedysville, Md.

16. Informant Mrs. Anna Dixon  
Address 1094 Murdock Ave. Hagerstown, Md.

17. Burial Date thereof April 27, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Maryland.

18. Funeral director Fred W. Kraiss  
Address Hagerstown, Maryland.

19. Apr. 25. 19 48 Blackburn  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

about 9p

20. DATE OF DEATH Apr/23/48 19....., at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19....., to..... 19.....  
and that I last saw h..... alive on ..... 19.....

Immediate cause of death..... DURATION  
arteriosclerotic coronary 2yrs

Due to heart disease

Due to acute coronary occlusion

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results..... no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... no Date of .....

Where did injury occur? ..... (City or town) (County) (State)

fell dead in a broer shop at work

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

DEPUTY MEDICAL EXAM.

23. SIGNATURE A. Robert Wells WASH. CO., MD.

Address Hagerstown, Md. Date signed 7/24/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

APR 27 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH *93d*Reg. Dist. No. *302*

04215

## 1. PLACE OF DEATH:

County..... Washington  
 City or town..... Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 20 years  
 Hospital, institution, or street address where death occurred:  
709 North Mulberry Street  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 709 North Mulberry Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war.....

## 3. (a) FULL NAME

George Dwight Dutrow

## 3. (b) Social Security Number

214-09-3929

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Single  
 6. (b) Name of husband or wife.....  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) October 23, 1883  
 8. AGE: Years..... 64 Months..... 5 Days..... 18 It less than one day..... hrs. .... min.

9. Birthplace..... Frederick County, Maryland  
 (Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business.....

MOTHER FATHER  
 12. Name..... M. C. Dutrow  
 13. Birthplace..... Fred. Co. Md.  
 14. Maiden name..... Sarah J. Warrenfeltz  
 15. Birthplace..... Fred. Co. Md.

16. Informant..... Daniel G. Dutrow  
 Address..... Hagerstown, Maryland

17. Burial Date thereof..... 4-13-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Rest Haven Cemetery  
 Location..... Hagerstown, Maryland

18. Funeral director..... C. M. Suter & Sons  
 Address..... Hagerstown, Maryland

19. Apr. 12 19 48 Charles B. Wood  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 10, 1948 at Rest M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10, 1943 to April 10, 1948  
 and that I last saw him alive on April 9, 1948  
 Immediate cause of death.....

DURATION  
Coronary Thrombosis 36 hours  
 Due to.....  
Cardio Vascular Disease 5 yrs  
 Due to.....  
Acute Cardiac Failure 1 week  
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results..... Yes

PHYSICIAN: Please underline the cause to which death should be charged statistically.

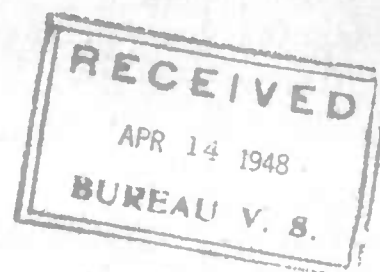
## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....  
 Where did injury occur? X X X X  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... W. Howard DeGroot M. D. or other  
Hagerstown, Md Date signed..... Apr. 10, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04216

Reg. Dist. No. 300

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Rural-Sharpshurg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 39 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Rural-Sharpshurg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... None

## 3. (a) FULL NAME

Daniel Edward Ebersole

## 3. (b) Social Security Number

220-10-3639

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
6. (b) Name of husband or wife <u>Mrs. Alta Ebersole</u>		
7. Birth date of deceased (mo., day, yr.) <u>May 10, 1909</u>		
8. AGE: Years <u>38</u>	Months <u>10</u>	Days <u>30</u>
If less than one day hrs. _____ min. _____		

6. (c) If alive, give age 28 years9. Birthplace... Antietam-Washington-Maryland  
(Town, county, and state)10. Usual occupation... Laborer11. Industry or business... Fairchild Air Craft-Hag. Md

12. Name... Charles Ebersole  
 13. Birthplace... White-Post--Virginia

14. Maiden name... Mary Marshall Holmes  
 15. Birthplace... Rural-Sharpshurg, Md

16. Informant... Mrs. Alta Ebersole  
 Address Rural--Sharpshurg, Maryland

17. Burial Date thereof April 12, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Mt. ViewLocation... Sharpshurg, Md.18. Funeral director... R. I. EarnshawAddress... Keedysville, Md19. 4/10 19 48  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... April 9, 1948 at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Post mortem to 19  
 and that I last saw him alive on 19

Immediate cause of death...

DURATION

Primary pneumonia 30 min

Due to...

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations...

Date of op. ....

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address...

Date signed 4/9/48

**RECEIVED**

MAY 7 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown, Maryland.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 23 years  
 Hospital, institution, or street address where death occurred:  
Washington Co. Hospital  
 How long in hospital or institution? 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland. County Washington  
 City or town Hagerstown.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Washed Miller St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

George Eshelman

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Helen Eshelman  
 7. Birth date of deceased (mo., day, yr.) Sept. 5, 1881 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 67 Months 7 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Greencastle, Penna.  
 (Town, county, and state)  
 10. Usual occupation Laborer  
 11. Industry or business

12. Name John Eshelman  
 13. Birthplace Penna.  
 14. Maiden name May Martin  
 15. Birthplace Penna.

16. Informant Mrs. Helen Eshelman  
 Address Hagerstown, Maryland.

17. Burial Date thereof April 13, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Marion, Penna.  
 Location Marion, Penna.

18. Funeral director Fred W. Kraiss  
 Address Hagerstown, Maryland.

19. Apr. 13, 48 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 9, 1948 at 9:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19, 1948 to April 9, 1948  
 and that I last saw him alive on April 9, 1948

Immediate cause of death Acute Encephalomyelitis  
(GUILLAIN-BARRE SYNDROME) DURATION 3 weeks

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions None

(Include pregnancy within 3 months of death).

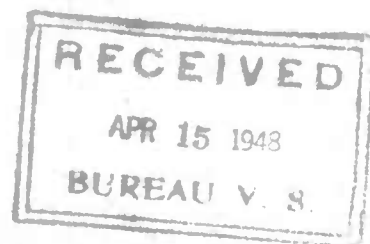
Major findings of operations No operation  
 Date of op. \_\_\_\_\_

Autopsy results No autopsy  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Ra Bee M. D. or other \_\_\_\_\_  
 Address Hagerstown Md. Date signed 4-10-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Cowcad  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 months 16 days  
 Hospital, institution, or street address where death occurred: Kilpatrick Hospital  
 How long in hospital or institution? 2 months 16 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Wicomico  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1025 Clinton St.  
 (If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Fred Bundy Espey

## 3. (b) Social Security Number

2

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

divorced

6. (b) Name of husband or wife .....

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

Aug 2, 1915

8. AGE:

Years

Months

Days

If less than one day

72824

.....hrs. ....min.

9. Birthplace

Baltimore, Md.  
(Town, county, and state)

10. Usual occupation

None - 11 years

11. Industry or business .....

12. Name

Unknown

13. Birthplace .....

14. Maiden name

Hubbourn

15. Birthplace .....

16. Informant

Address

John H. Espey  
1537 Covington St

17. (Burial, cremation, or removal, Which?)

Date the body

4/28/48  
(month) (day) (year)

Cemetery or crematory

Green Mount Cem

Location

Charles P. Towell

16. Funeral director

Address

2417 Edmondson Ave

19. (Date rec'd by registrar)

19

19

19

19

19

19

19

19

19

19

## MEDICAL CERTIFICATION

2D. DATE OF DEATH April 26 19 48 at 9<sup>05</sup> A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Feb 10 19 48 to April 26 19 48and that I last saw him alive on April 25 19 48Immediate cause of death Cardiac de-  
compensation

DURATION

6 days

Due to

Arteriosclerotic Heart  
Disease

Due to .....

Other conditions

Bronchiectasis  
Emphysema  
(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury .....

Injured at work?

23. SIGNATURE

Thomas M. Amptson, M.D.  
Kilpatrick Hospital  
Cowcad, Md

Address .....

M. D. or other

Date signed 4/26/48

67

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04213

## CERTIFICATE OF DEATH

Reg. Dist. No. 303

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Big Spring Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
 McCoy's Ferry Road  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Rural Big Spring, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... McCoy's Ferry Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

Ida May Everitts

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Amos Everitts  
 6. (c) If alive, give age... years  
 7. Birth date of deceased (mo., day, yr.) June 23, 1873  
 8. AGE: Years Months Days if less than one day  
 74 10 5 ... hrs. ... min.

9. Birthplace... Mercersburg, Franklin Co., Pa.  
 (Town, county, and state)

10. Usual occupation... Home Duties

## 11. Industry or business

12. Name... Thomas Armstrong

13. Birthplace... Franklin Co., Pa.

14. Maiden name... Mary Houck

15. Birthplace... Franklin Co., Pa.

16. Informant... Amos Everitts

Address... Big Spring, Md.

17. Burial Date thereat Apr. 30-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Shanktown Cemetery

Location... Shanktown, Md.

18. Funeral director... Snyder-Rowland Funeral Home

Address... Clear Spring, Md.

19. Date rec'd by registrar April 30 1948

20. Registrar Joseph W. Murray

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 28, 1948 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1946 to April 28, 1948

and that I last saw her alive on April 28, 1948

Immediate cause of death

Chronic Endocarditis 2 yrs.

Due to Arterio Sclerosis 10 yrs.

Myocardial Sclerosis 10 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David R. Brewer M.D.

M. D. or other

Address Clear Spring Md.

Date signed 4/30/48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131W

04220

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: **Washington**  
 County.....  
 City or town..... **Hagerstown, Maryland**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **35 years**  
 Hospital, institution, or street address where death occurred:  
**157 South Mulberry Street**  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... **Maryland** County..... **Washington**  
 City or town..... **Hagerstown**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **157 South Mulberry Street**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
**Margaret V. Fayman Fisher**

3. (b) Social Security Number  
**NONE**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Widow**  
 6. (b) Name of husband or wife **Norman Fisher**  
 7. Birth date of deceased (mo., day, yr.) **May 22, 1858**  
 6. (c) If alive, give age..... years  
 8. AGE: Years **89** Months **10** Days **9** It less than one day  
 hrs. min.

9. Birthplace **Martinsburg, W. Va.**  
 (Town, county, and state)  
 10. Usual occupation **Housework**  
 11. Industry or business  
 12. Name **James E. Fayman**  
 13. Birthplace **Shepherdstown, Maryland**  
 14. Maiden name **Margaret Unger**  
 15. Birthplace **Illinois**

16. Informant **Mrs. Mary Daugherty**  
 Address **Hagerstown, Maryland**  
 17. **Burial** Date thereof **4-4-48**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory **Christ Reformed Cemetery**  
 Location **Shepherdstown, W. Va.**

18. Funeral director **C. M. Suter & Sons**  
 Address **Hagerstown, Maryland**

19. **Apr. 3, 1948** **Frank Bowers**  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH **April 1st** 19 **48** at **3 A.** M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Mar 18** 19 **48** to **Apr 1st** 19 **48**  
 and that I last saw him/her alive on **Mar 31st** 19 **48**

Immediate cause of death.....  
**Chronic cardio-vascular**  
**renal disease.**  
 Due to.....  
**Cerebral Hemorrhage**  
**Hemiplegia**  
 Other conditions.....  
 (Include pregnancy within 8 months of death)

DURATION  
**8 yrs.**  
**2 yrs.**  
**2 yrs.**

Major findings of operations.....  
 Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

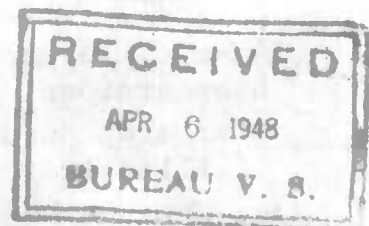
22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE **Ernest J. Golemb**  
 M. D. or other  
 Address **Hagerstown Md** Date signed **4/2/48**

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04221 306

## 1. PLACE OF DEATH:

County Washington  
 City or town Blue Ridge Summit  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Washington  
 City or town Blue Ridge Summit  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Daniel L. Flohr.

## 3. (b) Social Security Number

0

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

W.

6. (b) Name of husband or wife

Susan E. Mc. Clair

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

Feb. 6, 1866

8. AGE:

82222

If less than one day

hrs.

min.

9. Birthplace

Mountaindale Pa.  
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

Detrich S. Flohr

13. Birthplace

Adams Co. (Pa.)

MOTHER

14. Maiden name

Christiana Green

15. Birthplace

Adams Co. (Pa.)

16. Informant

Mr. William Flohr

Address

Waynesboro Pa.

17.

(Burial, cremation, or removal. Which?)

Date thereof

4/30/48  
(month) (day) (year)

Cemetery or crematory

Smithsburg

Location

" Md.

18. Funeral director

Walter U. Grove

Address

27 S. Church St. Waynesboro

19.

(Date rec'd by registrar)

April 28 48  
Geo. W. Ferguson  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

28 April19. 48at 1:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

17 April19. 48to 28 April19. 48

and that I last saw him alive on

10 P.M. 27 April19. 48

Immediate cause of death

Pneumonia, lobes, right

DURATION

2 weeks

Due to

Due to

Other conditions

Arteriosclerosis, Generalized, severe

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert D. Flohr, M.D.

M. D. or other

Address

Blue Ridge Summit, Pa.Date signed 28 April 48





04222

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

## 1. PLACE OF DEATH:

County WashingtonCity or town Bonshus  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred:

Bonshus Convalescent HomeHow long in hospital or institution? 3 weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No. W. Antietam St.  
(If rural, give LOCATION)2.(a) If veteran, name war - no. -

## 3. (a) FULL NAME

Howard Greenberry Ford

## 3. (b) Social Security Number

214-09-9537

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Maudie Edna Fuyre

## 6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

August 4 - 1879

## 8. AGE:

Years

Months

Days

It less than one day

68823

hrs.

min.

## 9. Birthplace

New Bonshus Wash. Co. Md.

(Town, county, and state)

## 10. Usual occupation

Attendant

## 11. Industry or business

Moose Lodge

## 12. Name

James P. Ford

## 13. Birthplace

New Bonshus Wash. Co. Md.

## 14. Maiden name

Malinda Young

## 15. Birthplace

New Bonshus Wash. Co. Md.

## 16. Informant

Mrs. Ralph Moore

## Address

Bonshus Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

Buried Date thereof April 29, 1948

(month) (day) (year)

## Cemetery or crematory

Bonshus Cemetery

## Location

Bonshus Md.

## 18. Funeral director

Clara J. Best 9800

## Address

Bonshus Md.

## 19. April 29

(Date rec'd by registrar)

19

48

John H. Best

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1948 at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 5 1948 to April 27 1948and that I last saw him alive on April 27 1948

Immediate cause of death

Arteriosclerosis of heart

Due to

Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John H. Best M. D. on 4/28/48Address Bonshus Md. Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Wade



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

## CERTIFICATE OF DEATH

Reg. Dist. No. 04223 304

1. PLACE OF DEATH.  
 County..... Washington  
 City or town..... Rural Hancock  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland County..... Washington  
 City or town..... Rural Hancock  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... R.F.D. #2  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

3. (a) FULL NAME  
Charles E. Fox

3. (b) Social Security Number

4. Sex..... Male  
 5. Color or race..... White  
 6.(a) Single, married, widowed, or divorced..... Married  
 6.(b) Name of husband or wife..... Martha Fox  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... June 21, 1867  
 8. AGE: Years..... 80 Months..... 9 Days..... 28 If less than one day..... hrs. .... min.

9. Birthplace..... Morgan Co. W. Va.  
 (Town, county, and state)  
retired farmer  
 10. Usual occupation.....  
 11. Industry or business.....  
 12. Name..... William Fox  
 13. Birthplace..... Virginia  
 14. Maiden name..... Virginia King  
 15. Birthplace..... Virginia

16. Informant..... Frank Fox  
 Address..... Warfordsburg, Pa.  
 17. Burial..... April 21, 1948  
 (Burial, cremation, or removal. Which?) Date thereof.....  
 (month) (day) (year)  
 Cemetery or crematory..... Bethel cemetery  
 Location..... Sleepy Creek, W. Va.  
 18. Funeral director..... Snyder-Rowland  
 Address..... Hancock, Md.  
 19. Apr 20 19 48  
 (Date rec'd by registrar) Registrar J. H. Heller

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 19, 19 48, at 4 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/3/1948 to Apr 19 48  
 and that I last saw him alive on Apr 19 48  
 Immediate cause of death.....  
 DURATION.....  
Chronic myocarditis  
valvular disease  
Chronic nephritis  
 Due to.....  
Grossly  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?  
 23. SIGNATURE..... M. H. Hager MD  
 M. D. or other  
 Address..... Hancock, Md. Date signed..... 4/20/48

RECEIVED

APR 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04224

## 1. PLACE OF DEATH:

County WashingtonCity or town Cascade  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 months 7 daysHospital, institution, or street address where death occurred:  
Reliance HospitalHow long in hospital or institution? 7 mos 7 days

## 3. (a) FULL NAME

Walter Harding Fuzzell

## 3. (b) Social Security Number

4. Sex Male5. Color or race white6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Marie Fuzzell

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1882

8. AGE: Years Months Days If less than one day

65 4 17 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Catonville, Md.  
(Town, county, and state)10. Usual occupation Varied

11. Industry or business

12. Name Ronald Fuzzell13. Birthplace Unknown14. Maiden name Laura Harding15. Birthplace Unknown16. Informant Harding P. FuzzellAddress 4108 Chatham Rd.17. Burial Date thereof April 23, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory CentralLocation New Market, Md.18. Funeral director Paul E. Chennamuth Jr.Address 3615-17 Chestnut Ave.19. 4-20-48 Dr. J. E. Jones  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Ball & BallCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1829 Fall St.  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 19 48 at 1:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 12 19 47 to April 19 19 48and that I last saw him alive on April 19 19 48Immediate cause of death Carcinoma of rectum DURATION 18 mos

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Arteriosclerotic Heart ?Disease

(Include pregnancy within 8 months of death)

Major findings of operation Perineal biopsy April 16, 1947 - adenocarcinoma Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Thomas M. Arrington, M.D. M. D. or otherAddress Reliance Hospital Date signed 4/19/48  
Cascade, Md.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04225

Reg. Dist. No. 302

1. PLACE OF DEATH  
 County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 wks  
 Hospital, institution, or street address where death occurred:  
Washington Co Hospital  
 How long in hospital or institution? 5 wks

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Pa County Franklin's  
 City or town Greencastle  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Center Square  
 (If rural, give LOCATION) ✓  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

HARRY T. GOETZ

## 3. (b) Social Security Number

none

4. Sex M 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Ella Little Goetz  
 7. Birth date of deceased (mo., day, yr.) Nov. 12, 1887  
 6. (c) If alive, give age 57 years

8. AGE: Years 60 Months 4 Days 19 If less than one day  
 hrs. min.

9. Birthplace Greencastle (Pa)  
 (Town, county, and state)

10. Usual occupation Contractor

11. Industry or business Self

12. Name Thomas M. Goetz

13. Birthplace Pa

14. Maiden name Mary C. Ruth

15. Birthplace Pa

16. Informant Mrs Ella Goetz

Address Chambersburg Pa

17. (Burial, cremation, or removal. Which?) Adm Hld Date thereof Apr 3/48  
 (month) (day) (year)

Cemetery or crematory Greencastle R

Location Greencastle R

18. Funeral director P. E. Munnich

Address Greencastle Pa

19. Apr. 2, 1948 Registrar Frank Bowers  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1948 at 6<sup>10</sup> A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1938 to March 3, 1948

and that I last saw him alive on March 27, 1948

Immediate cause of death Cerebral thrombosis DURATION 8 day

Due to hypertensive arteriosclerotic

cardio-vascular disease

Due to chronic nephrosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

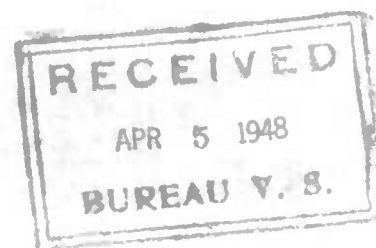
Means of injury Injured at work?

23. SIGNATURE T. B. Gilliland M. D. noted

Address Greencastle, Pa Date signed 4-1-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.







PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Campbell  
04226

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 Years  
 Hospital, institution, or street address where death occurred:  
12 Coffman Ave  
 How long in hospital or institution? ---

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 12 Coffman Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

ANDREW STOVER GORDON

## 3. (b) Social Security Number

705-10-5336

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Violet  
 6.(c) If alive, give age 58 years  
 7. Birth date of deceased (mo., day, yr.) June 1 1886  
 8. AGE: Years 61 Months 10 Days 24 It less than one day hrs. min.

9. Birthplace Clay Hill Franklin Co., Pa.  
(Town, county, and state)10. Usual occupation Frt. Conductor11. Industry or business W.M.R.R.

FATHER 12. Name Daniel Gordon  
 13. Birthplace Clay Hill Pa.  
 MOTHER 14. Maiden name Matilda Ovelnan  
 15. Birthplace Clay v Hill Pa.

16. Informant Mrs. Violet Gordon  
 Address Hagerstown Md.

17. Burial Date thereof 4/25/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rest Haven Cemetery  
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. Apr. 26, 48 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

D. S.T.

20. DATE OF DEATH April 25 1948 19 48 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
April 24 1948 to April 25 1948  
 and that I last saw him alive on April 24 1948

Immediate cause of death Cardiac Decompensation DURATION 2 days

Due to Acute RegurgitationDue to (Anterior sclerosis)  
Pass Rheumatic Carditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

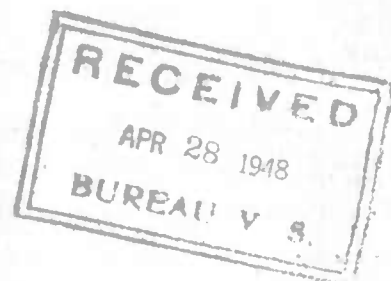
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert Vh Campbell M.D.  
 Address Hagerstown Md. Date signed 4/26/48  
 M. D. or other



RECEIVED

APR 28 1948

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

## CERTIFICATE OF DEATH

Dr. Ditto

04227

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown R # 4  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 27 Years  
 Hospital, institution, or street address where death occurred:  
Fairview Road  
 How long in hospital or institution? ---

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown R # 4  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Fairview Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

GEORGE McCLELLAND GORDON

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Gladys V.  
 7. Birth date of deceased (mo., day, yr.) August 30 1863  
 6.(c) If alive, give age 47 years  
 8. AGE: Years 84 Months 7 Days 22 hrs. min.

9. Birthplace Zullinger Franklin Co. Pa.  
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Retired

12. Name Alexander Gordon

13. Birthplace Shady Grove, Pa.

14. Maiden name Sarah Smith

15. Birthplace Shady Grove, Pa.

16. Informant George McC. Gordon

Address Hagerstown Md. R # 4

17. Burial Date thereof 4/25/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Dunkard Cemetery

Location Broadfording Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Apr. 23, 48 Registrar W. Bowers

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

P

20. DATE OF DEATH April 22 1948 19 2.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-47 19 4-22-48 19 48

and that I last saw him alive on 4-22-48 19 48

Immediate cause of death Cardio-renal failure

DURATION

Due to 6 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Antony results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

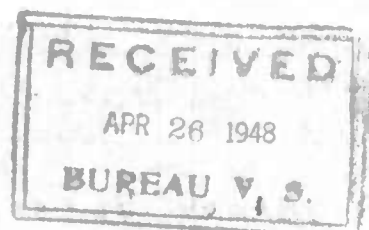
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE W. Bowers M. D. or other

Address Hagerstown Md. Date signed 4/23/48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04228

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 Years.  
 Hospital, institution, or street address where death occurred:  
 Washington County Hospital  
 How long in hospital or institution? 10 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants, give residence of mother)  
 Maryland Washington  
 State..... County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 2 Market Place.  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Carrie Grams

## 3. (b) Social Security Number

10

4. Sex Female  
 5. Color or race White  
 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Dennis F. Grams  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) February 24, 1894  
 8. AGE: Years Months Days If less than one day  
 54 1 10 hrs. min.

9. Birthplace Washington County, Md.  
 (Town, county, and state)  
 Home work  
 10. Usual occupation  
 11. Industry or business

12. Name Jonathan J. Williams  
 13. Birthplace Frederick County, Md.  
 14. Maiden name Annie M. Kriner  
 15. Birthplace Washington County, Md.  
 16. Informant Dorothy Mimmall,  
 Address Hagerstown, Md

17. Burial Date thereof April 6, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill  
 Location Hagerstown, Md.  
 Fred W. Kraiss.  
 18. Funeral director  
 Address Hagerstown.

19. Apr. 5, 1948  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1948 10 P.M.  
 at.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 November 4, 1947 to April 2, 1948  
 and that I last saw him alive on April 2, 1948

Immediate cause of death  
 1. Chronic valvular heart disease 3 yrs  
 with failure  
 2. Cerebral embolism 6 mo.  
 3. Embolism, popliteal artery 6 mo.  
 with gangrene (right leg)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address 148 W. Washington St Data signed 4-5-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

04229

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 day  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Md County Wash.  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Thelma Virginia Griffith

## 3. (b) Social Security Number

none

4. Sex F 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife \_\_\_\_\_  
 7. Birth date of deceased (mo., day, yr.) April 28, 1948 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Hagerstown-Washington-Maryland  
 (Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name R. A Griffith Jr.  
 13. Birthplace Keedysville, Md  
 14. Maiden name Thelma Hoffman  
 15. Birthplace Shepherdstown, W. Va

16. Informant Mrs. Thelma Griffith  
 Address Shepherdstown, W. Va.

17. Burial Date thereof April 30, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Belvoir

Location Hagerstown, Md

18. Funeral director R.I. Earnshaw

Address Keedysville, Md

19. Apr. 30 19 48 Blanchard  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 19 48 at 6:25P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-28-48 19 to 4-29-48 19  
 and that I last saw him alive on 4-29-48 19

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Pneumonia 6 1/2 m

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE N. S. W. Smith M. D. or other \_\_\_\_\_

Address Hagerstown, Md Date signed 4/30/48





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 w

04230

## CERTIFICATE OF DEATH

Reg. Diat. No.

302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hazelstam  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 weeks  
 Hospital, institution, or street address where death occurred:  
Washington Co Hospital  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Pa County Franklin  
 City or town near Greencastle  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. RD # 5 Chambersburg  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war Pa

## 3. (a) FULL NAME

MINNIE IRENE

GSELL

## 3. (b) Social Security Number

None

## 4. Sex

7

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Jacob A Gsell

## 7. Birth date of deceased (mo., day, yr.)

Feb 9, 1876

## 6. (c) If alive, give age

73 years

## 8. AGE:

Years

Months

Days

If less than one day

71

1

23

hrs.

min.

## 9. Birthplace

Penna

(Town, county, and state)

## 10. Usual occupation

House Wife

## 11. Industry or business

Home

## 12. Name

Minnie Seelers

## 13. Birthplace

not known

## 14. Maiden name

Susan Seelers

## 15. Birthplace

not known

## 16. Informant

Jacob A Gsell

## Address

Greencastle RD 3

## 17.

(Burial, cremation, or removal. Which?)

Date thereof

Apr. 4/88

## Cemetery or crematory

Brown mill

## Location

near Greencastle Pa

## 18. Funeral director

A. E. Murrell

## Address

Greencastle Pa

## 19.

(Date rec'd by registrar)

Apr. 2, 1948

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

4/1/2

19

at 12:30 A.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/1

19

4/2

19

and that I last saw her alive on

4/1

19

Immediate cause of death

arteriosclerotic cardiac-vascular-renal disease.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

J. E. Murrell

M. D. or other

Address

Greencastle Pa

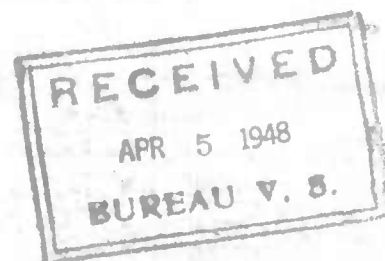
Date signed

4/2/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

04231

302

### 1. PLACE OF DEATH:

County... Washington  
City or town... Hagerstown, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 40 years  
Hospital, institution, or street address where death occurred:  
1202 Hamilton Blvd.  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State... Maryland County... Washington  
City or town... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1202 Hamilton Blvd.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Frances Jewell Harman

### 3. (b) Social Security Number

NONE

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow  
6.(b) Name of husband or wife Charles W. Harman  
6.(c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) August 10, 1878  
8. AGE: Years 69 Months 8 Days 1 If less than one day hrs. min.

9. Birthplace New York State  
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Edwin Blair Jewell  
13. Birthplace New York State  
MOTHER 14. Maiden name Aline Crosby  
15. Birthplace New York State

16. Informant Mrs. Aline Sowers

Address Hagerstown, Maryland

17. Burial Date thereof 4-13-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. Apr 12 48 Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH 4/9 - 1948 at 3a.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/9 - 1948 to 4/11 1948  
and that I last saw him alive on 4/10 1948

Immediate cause of death Cerebral thrombosis  
arterio-sclerosis DURATION 48 hours

Due to (?)

Other conditions  
(Include pregnancy within 8 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide no Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

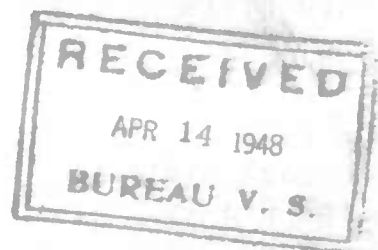
23. SIGNATURE V. D. Miller M. D. or other

Address 131 W. WASHINGTON S. Date signed 4/12 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 0423306 144

## 1. PLACE OF DEATH:

County WashingtonCity or town Cascade  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, institution, or street address where death occurred

Pelham HospitalHow long in hospital or institution? 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CharlesCity or town Bel Alton  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

George Harris

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

8. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

April 1, 1893

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

154

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace

St. Mary's County  
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

MOTHER FATHER

12. Name

Joe Harris

13. Birthplace

Hubertown

14. Maiden name

Rose Harrison

15. Birthplace

Hubertown

16. Informant

Pelham Hospital

Address

Cascade, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof April 8, 1948  
(month) (day) (year)

Cemetery or crematory

Location

Bel Alton, Md.

18. Funeral director

M. S. Clegg & Son

Address

Thurmont, Md.

19.

(Date rec'd by registrar)

April 6, 1948Blanche S. Eyer

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1948 at 2:02 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 2, 1948, to April 3, 1948and that I last saw him alive on April 4, 1948

Immediate cause of death

Carcinoma of Liver

DURATION

Unknown

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

Thomas M. Crompton, M.D.  
Pelham Hospital  
Cascade, Md.Address \_\_\_\_\_ Date signed 4/5/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 13 1948

BUREAU V. S.

Evidence for change of  
birth date shown on:  
HAM No. G 115 MAY 3 - 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04233

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 25 years  
Hospital, institution, or street address where death occurred:  
Washington County Hospital  
How long in hospital or institution? 6 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland. County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 32 Summer St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

Joseph Leonard Heflin

3. (b) Social Security Number

219-05-2697

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Helen R. Heflin

7. Birth date of deceased (mo., day, yr.) April 6, 1906 1916

8. AGE: Years 32 Months 0 Days 16 If less than one day hrs. min.

9. Birthplace Front Royal, Virginia  
(Town, county, and state)

10. Usual occupation Painter

11. Industry or business

12. Name Leonard R. Heflin

13. Birthplace Front Royal, Virginia

14. Maiden name Lula E. Cullers

15. Birthplace Bentonville, Virginia

16. Informant Leonard R. Heflin

Address 319 McDowell Ave.

17. Burial Date thereof April 25, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Maryland.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Maryland.

19. Apr 25, 1948 Registrar W. H. Bowers

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 1948 at 7:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Fractured skull DURATION 6 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 4/22/48

Where did injury occur? Hagerstown, Wash. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) 33 Wayside Ave.

Means of injury Fell off of porch Injured at work? yes

23. SIGNATURE S. Robert Mells DEPUTY MEDICAL EXAM. WASH. CO., MD.

Address Hagerstown, Md. Date signed 4/24/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The copy of this certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 27 1948

BUREAU V. S.





RECEIVED

MAY 7 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04235

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:

(Hagerstown) Washington CoHow long in hospital or institution? Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 919 Oak St  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Harmon G. House

## 3. (b) Social Security Number

none

4. Sex

M.

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Florence E. Powell

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Aug. 4<sup>th</sup> 1862

8. AGE:

Years

85

Months

8

Days

5

If less than one day

hrs.

min.

9. Birthplace

Frederick Co. Md.  
(Town, county, and state)

10. Usual occupation

Copper

11. Industry or business

Barrel

FATHER

12. Name

Samuel House

13. Birthplace

Maryland

MOTHER

14. Maiden name

Emma Metz

15. Birthplace

Maryland

16. Informant

Mrs. C. F. House

Address

919 Oak St Hagerstown Md.

17. Burial

Burial  
(Burial, cremation, or removal. Which?)Date thereof 4/12/48  
(month) (day) (year)

Cemetery or crematory

Hunkstons Cemetery

Location

Hunkstons Md.

18. Funeral director

L. F. Beecher

Address

Hunkstons Md.19. Apr 12 1948Chas H Bowers

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1948, at 7:28 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 7 1948 to Apr 9 1948and that I last saw him alive on April 8 1948

Immediate cause of death

Pulmonary disease

DURATION

3 days

Due to

Angocard

Due to

Other conditions

Senility

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. J. Layman M.D.

M. D. or other

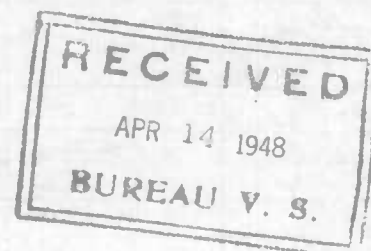
Address

Hagerstown Md

Date signed

Apr 12 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1312

04236

304

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County... WashingtonCity or town... Rural Hancock  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Rural Hancock  
(If outside city or town limits, write RURAL and give nearest town)Street No. near Sylvan, Pa.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Isaac A. Keefer

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Emma K. Keefer

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

August 9, 1864

## 8. AGE:

Years

Months

Days

If less than one day

83812

\_\_\_\_\_ hrs.

\_\_\_\_\_ min.

## 9. Birthplace

Franklin Co. Pa.

(Town, county, and state)

## 10. Usual occupation

retired farmer

## 11. Industry or business

## FATHER

## 12. Name

Peter A. Keefer

## 13. Birthplace

Pa.

## MOTHER

## 14. Maiden name

Henrietta Keefer

## 15. Birthplace

Franklin Co. Pa.

## 16. Informant

Mrs. Lottie V. Grove

## Address

Hancock, Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof April 25, 1948  
(month) (day) (year)

## Cemetery or crematory

Stone Bridge Cemetery

## Location

Sylvan, Pa.

## 18. Funeral director

Snyder-Rowland

## Address

Hancock, Md.

## 19. Date rec'd by registrar

Apr 24 1948

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 21, 1948 19 48, at 11:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 21 1948 to Apr 21 1948and that I last saw him alive on Apr 21 1948

Immediate cause of death

DURATION

Chronic myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

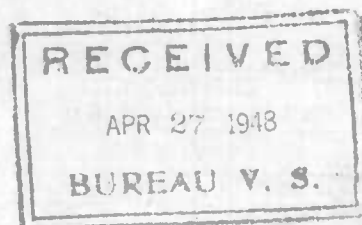
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



Evidence for change of

## MARYLAND STATE DEPARTMENT OF HEALTH

age shown on:

2411 N. Charles St., Baltimore

FILM No. G 115 MAY 11 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 300

## 1. PLACE OF DEATH:

County WashingtonCity or town Rural- Sharpsburg  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifetimeHospital, institution, or street address where death occurred:  
Sharpsburg RFD#3

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town RURAL- Sharpsburg RFD#3  
(If outside city or town limits, write RURAL and give nearest town)Street No. Near Taylors Landing  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Jacob H. Kidwiler

## 3. (b) Social Security Number

214-09-2928

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Nannie Kidwiler7. Birth date of deceased (mo., day, yr.) March 13, 18738. AGE: Years 75 Months 4 Days 0 It less than one day  
hrs. min.9. Birthplace Near Sharpsburg, Wash., Maryland  
(Town, county, and state)10. Usual occupation Laborer11. Industry or business On farm12. Name Michael P. Kidwiler13. Birthplace Washington County, Maryland14. Maiden name Barbara Houser15. Birthplace Washington County, Maryland16. Informant Mary GatrellAddress Taylor's Landing, Md.17. Burial Date thereof April 16, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mountain View CemeteryLocation Sharpsburg, Maryland18. Funeral director Mrs. Edith V. LeafAddress Williamsport, Md.19. 4/15 1948  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13/48 1948 at 10:30 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
4/2/48 1948 to 4/13/48 1948  
and that I last saw him alive on 4/13/48 1948Immediate cause of death Cerebral Apoplexy DURATION 3 daysDue to Hypertension 3 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. F. Goring M. D. or otherAddress Williamsport, Md. Date signed 4/14/48

MARGIN RESERVED FOR BINDING

I

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 7 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04238

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 days  
 Hospital, institution, or street address where death occurred:  
Washington Co. Hospital  
 How long in hospital or institution? 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1108 Beechwood Drive  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Richard Eugene Kline, Junior  
 INFANT

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white single

6.(b) Name of husband or wife None

6.(c) If alive, give age years

T. Birth date of deceased (mo., day, yr.) 4-18-48

8. AGE: Years Months Days If less than one day  
0 0 6 hrs. min.

9. Birthplace Washington Co. Hosp, Hagerstown, Md.  
 (Town, county, and state)

10. Usual occupation NONE

11. Industry or business

12. Name Richard E. Kline

13. Birthplace HAGERSTOWN

14. Maiden name Almira Virginia Stauffer

15. Birthplace Hagerstown

16. Informant Richard E. Kline

Address 1108 Beechwood Drive Hagerstown Md

17. Burial Date thereof 4/20/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown Md.

18. Funeral director L.H. Beecher

Address Frankstown Md.

19. Apr. 25 1948 Health Officer  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4-28 1948 at 12:01 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-18 1948 to 4-28 1948 and that I last saw him alive on 4-28 1948

Immediate cause of death Premature Birth

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations NONE

Date of op.

Autopsy results PULMONARY ATELECTASIS

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Anne S. Nichols M.D.

M. D. or other

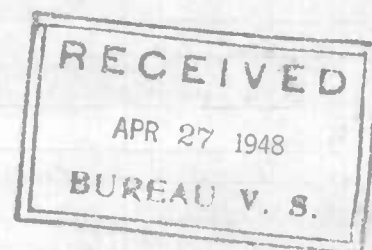
Address Wash Co Hosp, Hagerstown Date signed 4-25

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County WashingtonCity or town Cascade

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months - 21 days

Hospital, institution, or street address where death occurred:

Kitchie HospitalHow long in hospital or institution? 6 months 21 days

## 3. (a) FULL NAME

George A Koenig

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Grace Wilhelm

7. Birth date of

deceased (mo., day, yr.)

June 28<sup>th</sup> 18916. (c) If alive, give age 50 years

8. AGE:

Years

56

Months

8

Days

10

If less than one day

hrs.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Machinist

11. Industry or business

Western Maryland Drug

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

18. Informant

Mrs. Ethel Brown

Address

2572 Mosher St

17.

(Burial, cremation, or removal. Which?)

BurialDate thereof April 19/48

(month) (day) (year)

Cemetery or crematory

Meadows Ridge Memorial

Location

Charles P. Towell Park

18. Funeral director

Charles P. Towell

Address

2427 Edmondson Ave

19.

(Date rec'd by registrar)

April 7 1948

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1813 Monroe St

(If rural, give LOCATION)

2. (a) If veteran, name war ✓

## 3. (b) Social Security Number

215-10-2435

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1948, at 8:43 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 17 1947, to April 8 1948and that I last saw him alive on April 8 1948

Immediate cause of death

Cerebral hemorrhage

DURATION

10 days

Due to

Due to

Other conditions

Repetitive C.V. DiseaseCerebral hemorrhage

(Include pregnancy within 3 months of death)

Deaf-mutism

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE Thomas M. Armstrong, M.D.Address Kitchie Hospital Date signed 4/8/48Cascade, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04240

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... WASHINGTON  
 City or town... HAGERSTOWN  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 51 YRS.  
 Hospital, institution, or street address where death occurred:  
177 N. LOCUST STREET  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... MARYLAND County... WASHINGTON  
 City or town... HAGERSTOWN  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 177 N. LOCUST ST.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... NON-VET.

## 3. (a) FULL NAME

HDA SNAVELY KRETZER

## 3. (b) Social Security Number

NONE

## 4. Sex

FEMALE

## 5. Color or race

WHITE

## 6. (a) Single, married, widowed, or divorced

MARRIED

## 6. (b) Name of husband or wife

HELIAM KRETZER

## 7. Birth date of deceased (mo., day, yr.)

FEBRUARY 22, 1864

## 6. (c) If alive, give age

83 years

## 8. AGE:

Years 84 Months 1 Days 14 If less than one day  
 ...hrs. ...min.

## 9. Birthplace

SHARPSBURG WASHINGTON, MD.  
 (Town, county, and state)

## 10. Usual occupation

HOUSEWIFE

## 11. Industry or business

## FATHER

12. Name... MILLARD SNAVELY

## 13. Birthplace

SHARPSBURG, MD

## MOTHER

14. Maiden name... LORETHA ZIMMERMAN

## 15. Birthplace

SHARPSBURG, MD.

## 16. Informant

Mrs. Mabel E. Moore, daughter

## Address

177 N. Locust St.

## 17. (Burial, cremation, or removal. Which?)

Burial Date thereof... 4/9/48  
 (month) (day) (year)

## Cometary or crematory

Rose Hill

## Location

Hagerstown Md.

## 18. Funeral director

W. J. Harman

## Address

Hagerstown Md.

## 19. (Date rec'd by registrar)

Apr. 20 19 48 B. H. H. B. B. B.  
 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... April 6, 1948 at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 1944 to April 6, 1948

and that I last saw her alive on March 29, 1948

## Immediate cause of death

Hypertensive cardiovascular disease,

## DURATION

3 years

## Due to

None

## Due to

None

## Other conditions

None

(Include pregnancy within 3 months of death)

## Major findings of operations

No operation

## Autopsy results

No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

## 23. SIGNATURE

R. B. B.  
 Address... Hagerstown Md. Date signed... 4/7/48

Dr. R. A. Bell  
119 N. Potomac

RECEIVED

APR 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

04241

303

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Rural - Clearsprings, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Residence

How long in hospital or institution?

## 3. (a) FULL NAME

Frederick Harry Leshner

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Matilda B. Leshner

7. Birth date of

deceased (mo., day, yr.)

1877

8. AGE:

Years

Months

Days

If less than one day

71

hrs.

min.

9. Birthplace

Washington Co., Maryland.

10. Usual occupation

Laborer

11. Industry or business

Isaac Leshner

FATHER

12. Name

13. Birthplace

Washington Co., Maryland.

MOTHER

14. Maiden name

Catherine Tice

15. Birthplace

Washington Co., Maryland.

16. Informant

Mrs. Matilda Leshner

Address

Clearsprings, Md. Rural Route 40

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

April 22, 1948

Cemetery or crematory

St. Pauls Cemetery

Location

U.S. Route # 40, E. of Clearsprings, Maryland.

18. Funeral director

Snyder &amp; Rowland

Address

Clearsprings, Maryland.

19. April 22, 1948

(Date rec'd by registrar)

Joseph A. Murray

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland. County... WashingtonCity or town... Clearsprings, Md. Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

U.S. Route # 40

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 19, 1948, at 3P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1940 -

19

to

April 19, 1948

and that I last saw him alive on

April 17, 1948

Immediate cause of death

Coronary Occlusion

DURATION

Sudden

Due to

Htg Arterio Sclerosis

8 yrs

Due to

Myocardial Sclerosis

5 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

David P. Brewer M.D.

M. D. or other

Address

Clear Spring Md

Date signed 4/22/48

RECEIVED

APR 27 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

04242

## 1. PLACE OF DEATH

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Boonsboro  
(If outside city or town limits, write RURAL and give nearest town)Street No. N. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war no.

## 3. (a) FULL NAME

William Henry McAvoy

## 3. (b) Social Security Number

219-01-9148

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed or divorced

Single

6. (b) Name of husband or wife

Single

7. Birth date of

deceased (mo., day, yr.)

November - 5 - 1911

8. AGE:

Years

Months

Days

If less than one day

36520

hrs.

min.

9. Birthplace

Baltimore Md.  
(Town, county, and state)

10. Usual occupation

Retired Employee

11. Industry or business

Child aircraft

FATHER

12. Name

John W. McAvoy

MOTHER

13. Birthplace

Baltimore Md.

14. Maiden name

Stella Mae Smith

15. Birthplace

Boonsboro Md.

16. Informant

Mrs Stella M. McAvoy

Address

Boonsboro Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

April 28 1948  
(month) (day) (year)

Cemetery or crematory

Boonsboro Cemetery

Location

Boonsboro Md.

18. Funeral director

Wm. J. Bateman

Address

Boonsboro Md.

19.

(Date rec'd by registrar)

Apr. 27 1948  
Wm. J. Bateman  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April - 25 - 1948 at 7:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 25 - 1948, to 1948and that I last saw him alive on Apr 25 1948

Immediate cause of death

DURATION

Cerebral Hemorrhage1 1/2 hrs.

Due to

Malignant Hypertension1 yr +.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

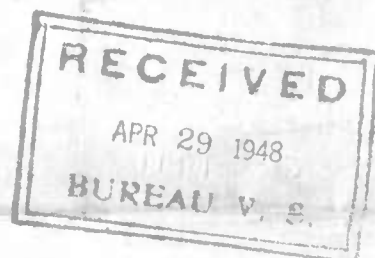
Means of injury

Injured at work

23. SIGNATURE

Walter H. Shealy M.D.  
Sharpsburg, Md.  
Address Sharpsburg, Md. Date signed 4/27/48





04243

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 301

## 1. PLACE OF DEATH:

County Washington

City or town Williamsport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Lifetime

Hospital, institution, or street address where death occurred:

121 West Potomac

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Washington

City or town Williamsport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 121 West Potomac St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Effie Rachel McCardell

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife R. Eugene McCardell

6. (c) If alive, give age years

## 7. Birth date of

deceased (mo., day, yr.) Jan. 25, 1868

## 8. AGE:

Years

Months

Days

If less than one day

80

3

0

hrs.

min.

## 9. Birthplace

Williamsport, Wash. Maryland

(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

At Home

## MOTHER

## 12. Name

Jerome King

## 13. Birthplace

Williamsport, Md.

## MOTHER

## 14. Maiden name

Rachel Shook

## 15. Birthplace

Williamsport, Md.

## 16. Informant

Norman R. McCardell

## Address

Williamsport, Maryland.

## 17.

Burial

Date thereof April 30, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

Riverview Cemetery

## Location

Williamsport, Maryland

## 18. Funeral director

Edith V. Leaf

## Address

Williamsport, Maryland.

## 19.

4/30/48

19

Mrs. E. Lee McElroy

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

April 25, 1948

at 4 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1, 1948, to April 25, 1948

and that I last saw him alive on April 25, 1948

Immediate cause of death

DURATION

Due to

Myocarditis Chronic

4 mos.

Due to

Anterior Sclerosis

4 mos.

Other conditions

Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. M. McElroy

M. D. or other

Address

Williamsport, Md.

Date signed

4/24/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Ditto

04244

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 Years  
 Hospital, institution, or street address where death occurred:  
1400 Salem Ave.  
 How long in hospital or institution? ---

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1400 Salem Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

MRS. LILLIAN SHUMAN MEYNCKE

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Charles  
 6.(c) If alive, give age --- years  
 7. Birth date of deceased (mo., day, yr.) November 15, 1856  
 8. AGE: Years 91 Months 5 Days 0 It less than one day --- hrs. --- min.

9. Birthplace Columbia, Lancaster Co., Penna.  
 (Town, county, and state)

10. Usual occupation House Wife11. Industry or business Own Home

FATHER 12. Name John Shuman  
 13. Birthplace Columbia Pa.  
 MOTHER 14. Maiden name Rebecca Brown  
 15. Birthplace Maytown Pa.

16. Informant Carl S. Meyncke  
 Address Hagerstown Md.

17. Burial Date thereof 4/17/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Luthern Cemetery  
 Location Maytown Penna.

18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. Apr. 16, 1948 Pharff Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 19 48 at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-11-48 19 48 to 4-15-48 19 48  
 and that I last saw him alive on 4-11-48 19 48

Immediate cause of death Congestive Venous Failure

DURATION

6 yrsDue to ---Due to ---Other conditions ---

(Include pregnancy within 3 months of death)

Major findings of operations ---Date of op. ---Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---Where did injury occur? --- (City or town) (County) (State)Injured at home, farm, industry, public place (where?) ---Means of injury --- Injured at work? ---23. SIGNATURE Pharff Bowers M. D. or other ---Address Hagerstown Md. Date signed 4/16/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. W. Oaklander

04245

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 week  
 Hospital, institution, or street address where death occurred:  
Childrens Hospital  
 How long in hospital or institution? 1 Week

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Childrens Hospital  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

RUTH ELIZABETH MORNINGSTAR

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife  
 6.(c) If alive, give age --- years  
 7. Birth date of deceased (mo., day, yr.) January 11 1948  
 8. AGE: Years Months Days If less than one day  
- 3 18 hrs. min.

9. Birthplace Hagerstown Wash. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Infant  
 11. Industry or business

12. Name David Morningstar  
 13. Birthplace Kearneysville W. Va.  
 14. Maiden name Daisy B. Johnson  
 15. Birthplace Martinsburg W. Va.

16. Informant David Morningstar  
 Address Hagerstown Md.

17. Burial Date thereof 4/30/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Mt. Zion Cemetery  
 Location Kearneysville W. Va.

18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. Apr. 29 - 19 48 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1948 19 48 at 3 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 11 1948 to 29 April 1948 and that I last saw her alive on 28 April 1948

Immediate cause of death Congenital Heart Disease DURATION 3 mo 18 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edm. S. Howell M.D. M. D. or other

Address 115 W. Main St. Date signed 29 April 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH 73d

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... **Washington**  
 City or town... **Hagerstown**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **34 years**  
 Hospital, institution, or street address where death occurred:  
**331 Jefferson St.**  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland** County **Washington**  
 City or town... **Hagerstown**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **331 Jefferson St.**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

**John Ezra Musey Sr.**

## 3. (b) Social Security Number

**214-09-1458**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Married**  
 6. (b) Name of husband or wife **Hazel N. Musey**  
 7. Birth date of deceased (mo., day, yr.) **December 10, 1909** 6. (c) If alive, give age **39** years  
 8. AGE: Years **38** Months **4** Days **16** If less than one day  
 hrs. min.

9. Birthplace **Waynesboro Franklin Co. Pa.**  
 (Town, county, and state)

10. Usual occupation **Bookkeeper**  
 11. Industry or business **Wantz Bottling Works**

MOTHER 12. Name **J. Ezra Musey**  
 13. Birthplace **Hagerstown Md.**  
 14. Maiden name **Clara B. White**  
 15. Birthplace **Hagerstown Md.**

16. Informant **Fred Musey**  
 Address **Hagerstown Md.**

17. Burial **April 28, 1948**  
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory **Rose Hill Cemetery**  
**Hagerstown Md.**

Location **Scott F. Minnich & Son**

18. Funeral director **Hagerstown Md.**  
 Address

19. **Apr. 28, 1948**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH **April 26 1948** at **4:15a** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **April 13, 1948** to **April 26, 1948**  
 and that I last saw him alive on **April 25, 1948**

Immediate cause of death **Polycystic disease of both lungs** DURATION **Congenital**

Due to.....  
 Due to.....

Other conditions **Myocardial failure** **3 days**

(Include pregnancy within 3 months of death)

Major findings of operations **NONE**

Autopsy results **Polycystic disease of lungs - Chronic myocarditis**  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....

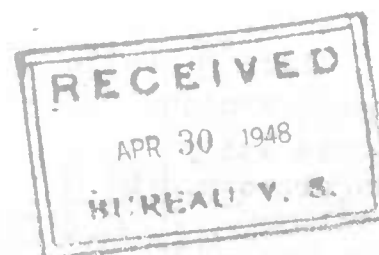
Where did injury occur? **Home**  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE **RB Jorment mo** M. D. or officer **4/27/48**  
 Address **Hagerstown Md** Date signed





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04247

Reg. Dist. No. 307

## 1. PLACE OF DEATH:

County Washington  
 City or town Sandy Hook  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 59 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Sandy Hook  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2(a) If veteran, name war None

## 3. (a) FULL NAME

Ross, Conkling Nelson

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife None  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) March 20, 1889  
 8. AGE: Years 59 Months 1 Days 9 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Sandy Hook, Washington Co., Md.  
 (Town, county, and state)

10. Usual occupation Railroad Brakeman (Retired)

11. Industry or business B. & O. Railroad

FATHER 12. Name William Henry Nelson

13. Birthplace Maryland

MOTHER 14. Maiden name Eliza Jane Ross

15. Birthplace Strasburg, Virginia

16. Informant Mrs. Henry Holder

Address RFD # 1, Knoxville, Maryland

17. Burial Burial Date thereof May 2, 1948  
 (Burial, cremation, or removal. Which?) (Month) (day) (year)

Cemetery or crematory Brownsville Cemetery

Location Brownsville, Maryland

18. Funeral director Melvin T. Striser

Address Charles Town, West Va.

19. Apr. 30 1948 Bonnelina H. Smith  
 (Date rec'd by registrar) Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 29, 1948 1948 at 1:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 47 to April 28, 1948  
 and that I last saw him alive on April 28, 1948

Immediate cause of death Coronary failure DURATION \_\_\_\_\_

Due to chronic myocarditis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

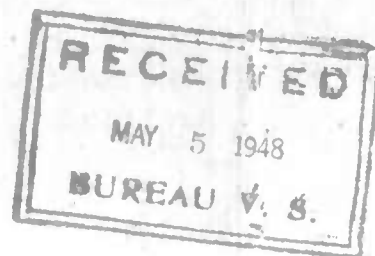
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE [Signature] M. D. or other \_\_\_\_\_

Address Brownsville, Md Date signed 4-29-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 305-

## 1. PLACE OF DEATH:

County Washington  
 City or town Saville, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 14 years  
 Hospital, institution, or street address where death occurred:  
Salisbury Memorial Home  
 How long in hospital or institution? 14 yrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Rohersville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Rural  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war no.

## 3. (a) FULL NAME

Savilla Morris

## 3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife Single  
 7. Birth date of deceased (mo., day, yr.) November - 4 - 1858  
 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Year 89 Months 5 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Rohersville Md.  
 (Town, county, and state)

10. Usual occupation None

11. Industry or business \_\_\_\_\_

12. Name Haratis Morris  
 13. Birthplace Rohersville Md.

14. Maiden name Susan Bersburg  
 15. Birthplace Burkittsville Md.

16. Informant Records of Salisbury Memorial Home  
 Address Brownsville Md. R. 2

17. Burial Date thereof April 24, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rohersville Cemetery  
 Location Rohersville Md.

18. Funeral director Rev. J. B. B. B. B.  
 Address Brownsville Md.

19. April 24, 1948 John H. B. B. B.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April - 22 19 48 at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 16 19 48 to April 22 19 48 and that I last saw him alive on April 21 19 48

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Chronic Myocarditis 10 yrs.

Due to arteriosclerosis 10 yrs.

Due to gangrene of right foot 2 yrs.

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

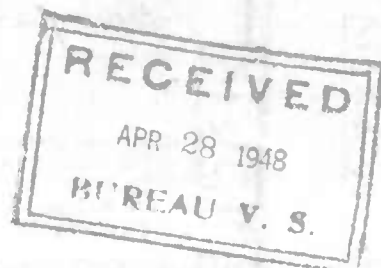
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE \_\_\_\_\_ M. D. or other \_\_\_\_\_

Address Brownsville, Md. Date signed 4/23/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

04249

302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?... Life  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution?... Few Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 527 West Church Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

John A. O'Brian

## 3. (b) Social Security Number

214-09-2321

4. Sex... Male 5. Color or race... White 6.(a) Single, married, widowed, or divorced... Married  
 6.(b) Name of husband or wife... Lyla E. O'Brien  
 6.(c) If alive, give age... 60 years  
 7. Birth date of deceased (mo., day, yr.)... June 6, 1887 Maryland  
 8. AGE: Years... 60 Months... 10 Days... 8 If less than one day... hrs. min.

9. Birthplace... Frederick, Maryland  
 (Town, county, and state)  
 10. Usual occupation... Watchman  
 11. Industry or business... Hager House  
 12. Name... John R. O'Brien  
 13. Birthplace... Frederick, Maryland  
 14. Maiden name... Sarah Keller  
 15. Birthplace... Frederick, Maryland

16. Informant... Mrs. John A. O'Brien  
 Address... Hagerstown, Maryland  
 17. Burial... Burial Date thereof... 4-16-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... Rest Haven Cemetery  
Hagerstown, Maryland  
 Location...  
 18. Funeral director... C. M. Suter & Sons  
 Address... Hagerstown, Maryland

19. Apr. 16, 1948 Shorttowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... April 14, 1948 at 11:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... , to... 19...  
 and that I last saw him... alive on... 19...

Immediate cause of death...  
Gunshot wound into chest.  
 Due to...  
 Due to...  
 Other conditions...  
 (Include pregnancy within 3 months of death)

Major findings of operations... None  
 Date of op...  
 Autopsy results... None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Suicide Date of... 4/14/48  
 Where did injury occur? Hagerstown Wash. Md.  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)... Home  
 Means of injury... shot self with 12 gauge Injured at work? No

23. SIGNATURE... S. R. Shorttowers DEPUTY MEDICAL EXAM.  
Hagerstown, Md. M. D. or other...  
 Address... Hagerstown, Md. Date signed... 4/15/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

## CERTIFICATE OF DEATH

Reg. Dist. No.

04250

302

## 1. PLACE OF DEATH:

County WASHINGTON  
 City or town HAGERSTOWN  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 yrs 6 months  
 Hospital, institution, or street address where death occurred:  
553 FREDERICK STREET  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MARYLAND County WASHINGTON  
 City or town HAGERSTOWN  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 553 FREDERICK STREET  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war Non-VET.

## 3. (a) FULL NAME

LAURA ELLEN

## 3. (b) Social Security Number

NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced WIDOWED  
 6. (b) Name of husband or wife HARRY W. PALMER  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) DECEMBER 14, 1871  
 8. AGE: Years 76 Months 4 Days 1 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace WOLFVILLE FREDERICK, MD.  
 (Town, county, and state)  
 10. Usual occupation HOUSEWIFE  
 11. Industry or business

12. Name DAVID FARSH  
 13. Birthplace MARYLAND  
 14. Maiden name MARGARET ECCARD  
 15. Birthplace MARYLAND  
 16. Informant Hollie M. Martin  
 Address 553 Frederick St  
Burial Date thereof 4/18/48  
 (Burial, cremation, or removal? Which?) (month) (day) (year)  
 Cemetery or crematory Wolfville United Brethren  
 Location Frederick County Md.  
 18. Funeral director W. J. Fournier  
 Address Hagerstown Md.  
 19. Apr 16, 1948 Chas. Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Apr 48 19\_\_\_\_ at 11:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
15 Feb 1946, to 15 Apr 1948  
 and that I last saw her alive on 13 Apr 48 19\_\_\_\_

Immediate cause of death Aorta Sclerotic Cardio Vascular Disease DURATION 10 yrs +

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_. Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. J. Lusby M. D. or other \_\_\_\_\_Address 23 ON Potomac Date signed 16 Apr 48





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

### 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 25 years  
Hospital, institution, or street address where death occurred:  
Washington County Hospital  
How long in hospital or institution? 7 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1131 Oak Hill Avenue  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Raymond Wakeman Parks

### 3. (b) Social Security Number

214-09-8965

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Sylvia G. Parks  
6. (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) November 1, 1895

8. AGE: Years 52 Months 5 Days 20 If less than one day  
hrs. min.

9. Birthplace Texas, Maryland  
(Town, county, and state)

10. Usual occupation Owner

11. Industry or business Hagerstown Dairy

12. Name Eugene Parks

13. Birthplace Maryland

14. Maiden name Genevise Eckart

15. Birthplace Cecil Co. Maryland

16. Informant Mrs. Raymond W. Parks

Address Hagerstown, Maryland

17. Burial 4-23-48  
(Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. Apr. 22, 48 Brooks Powers  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 19 48 at 3:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 19 47, to April 21 19 48

and that I last saw him alive on April 21 19 48

Immediate cause of death

angina pectoris (mild) DURATION 13 mo.

Due to Lobar pneumonia

(Type unknown) 6 d.

Due to myocardial congestive

Other conditions heart failure grade IV 6 d.

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE A Robert Wells, Jr. D. M. D.

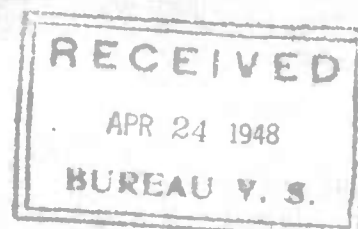
Address Hagerstown, Md. Date signed 4/21/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04252

## CERTIFICATE OF DEATH

Reg. Dist. No. 307

### 1. PLACE OF DEATH:

County Washington  
City or town Pleasantville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 17 years  
Hospital, institution, or street address where death occurred:  
R.F.D.#1, Harpers Ferry, West Va.  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Pleasantville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. R.F.D.#1, Harpers Ferry, West Va.  
(If rural, give LOCATION)  
2(a) If veteran, name war None

### 3. (a) FULL NAME

Ivy Blanch Penner

### 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Jacob Solomon Penner  
6. (c) If alive, give age 49 years  
7. Birth date of deceased (mo., day, yr.) October 13, 1897  
8. AGE: Years 50 Months 5 Days 23 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Oakland, Maryland  
(Town, county, and state)  
10. Usual occupation Housewife  
11. Industry or business Own Home  
FATHER 12. Name William Clark  
13. Birthplace Oakland, Maryland  
MOTHER 14. Maiden name Lillian Bowers  
15. Birthplace Hutton, West Virginia

16. Informant Mr. Jacob S. Penner  
Address R.F.D.#1, Harpers Ferry, West Va.  
17. Burial Burial Date thereof 4/8/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Samples Manor Cemetery  
Location Samples Manor, Maryland  
18. Funeral director Merlin T. Strider  
Address Charles Town, West Va.

19. April 6 1948 Bernadine Th. Castle  
(Date rec'd by registrar) Deputy Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1948 1948 at 10:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 12, 1947 to April 5, 1948  
and that I last saw him FR alive on March 30, 1948

Immediate cause of death Cerebral aneurysm, ruptured. DURATION 10 min.

Due to Adrenocortical insufficiency, bilateral.

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)  
Major findings of operations Adrenocortical insufficiency. Date of op. Sept. 47.

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Q. P. Smith M.D. M. D. or other \_\_\_\_\_  
Address Baltimore, Md Date signed 4-6-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

04253

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 31 years  
 Hospital, institution, or street address where death occurred:  
1815 Heisterboro Road  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1815 Heisterboro, Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3.(a) FULL NAME

Luella I. Perham3.(b) Social Security Number  
None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Vaughan A. Perham  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) July 11, 1870  
 8. AGE: Years 77 Months 8 Days 28 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Waynesboro, Penna.  
 (Town, county, and state)  
 10. Usual occupation Home duties  
 11. Industry or business

FATHER 12. Name John R. Hoeflich  
 13. Birthplace Penna.  
 MOTHER 14. Maiden name Mary C. Besser  
 15. Birthplace Penna.

16. Informant Miss Mildred Perham  
 Address 1815 Heisterboro, Road

17. Burial Date thereof April 8, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Rest Haven Cemetery  
 Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss  
 Address Hagerstown, Md.

19. Apr. 10, 48 Registrar W. Bowers  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 8, 1948 1:20 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-48 to 4-8-48  
 and that I last saw him alive on 4-7-48

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_  
Cerebral Vascular Lesion 10 yrs  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE W. Bowers M. D. or other \_\_\_\_\_  
 Address Hagerstown, Md. Date signed 4/8/48

**RECEIVED**

APR 13 1948

**BUREAU V. S.**

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

## CERTIFICATE OF DEATH

04254 302  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 days  
Hospital, institution, or street address where death occurred:  
Washington Co. Hospital, Hagerstown MD.  
How long in hospital or institution? 4 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Robertsville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Benjamin POTTENBERGER

### 3. (b) Social Security Number

None

4. Sex male 5. Color or race wh. 6.(a) Single, married, widowed, or divorced married  
6.(b) Name of husband or wife Daisy L. POTTENBERGER  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) Oct. 19. 1874  
8. AGE: Years 74 Months 7 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace ROHRESVILLE, M.D.  
(Town, county, and state)  
10. Usual occupation Retired farmer  
11. Industry or business \_\_\_\_\_

FATHER 12. Name SAMPSON POTTENBERGER  
13. Birthplace M. ROHRESVILLE WASH. CO. MD.  
MOTHER 14. Maiden name SUSAN PALMER  
15. Birthplace M. MYERSVILLE, FRED. CO. MD.

16. Informant DAISY L. POTTENBERGER  
Address ROHRESVILLE, MD.

17. BURIAL Date thereof APR. 6 - 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory ROHRESVILLE CEMETERY  
Location ROHRESVILLE, MD.

18. Funeral director Wm. F. Bast: son  
Address Brownstown, Md.

19. Apr. 5. 1948 Registrar Charles B. Bower  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4 1948, at 1:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/31 1948, to 4/4 1948  
and that I last saw him alive on 4/3/48 1948

Immediate cause of death Essential Hypertension DURATION 2 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Pulmonary Edema  
Hypertensive cardio-vascular disease  
(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Marjorie J. Gallibor M.D.  
Hagerstown Md. M. D. or other \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 4/14/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

APR 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 25 years  
 Hospital, institution, or street address where death occurred:  
427 Mechanic Street  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 427 Mechanic Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Peter Parley Ragland

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Mattie L. Ragland  
 6.(c) If alive, give age... years  
 7. Birth date of deceased (mo., day, yr.) May 29, 1880  
 8. AGE: Years 67 Months 10 Days 14 If less than one day  
 hrs. min.

9. Birthplace Buckingham Co. Va.  
 (Town, county, and state)  
 10. Usual occupation Night Watchman  
 11. Industry or business

12. Name Unknown  
 13. Birthplace Unknown  
 14. Maiden name Unknown  
 15. Birthplace

16. Informant Harry Ragland  
 Address Hagerstown, Maryland  
 17. Burial Date thereof April 15, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown, Maryland  
 18. Funeral director Fred W. Kraiss  
 Address Hagerstown, Maryland

19. Apr. 14, 48 19 48 Charles H. Howard  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 48 at 5:10 P.  
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from  
April 5, 48 to April 12, 48  
 and that I last saw him alive on April 11, 48

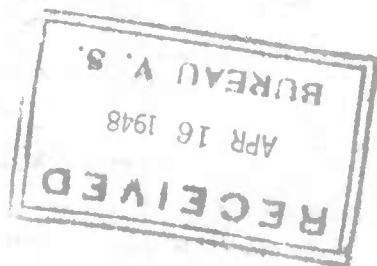
Immediate cause of death Pulmonary edema DURATION 3 days  
 Due to hypertension, cardiac ?  
vascular disease  
 Due to  
 Other conditions Old left heart 6 mo.  
hemiplegia  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE W. J. Layman, M.D. M. D. or other  
Hagerstown Md. Address Date signed 15 April 1948



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04256  
302  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 10 years  
Hospital, institution, or street address where death occurred:  
On the Street Summit Avenue  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 82 Summit Avenue  
(If rural, give LOCATION)  
2.(a) If veteran, name war World War #1

### 3. (a) FULL NAME

John Ramsey

### 3. (b) Social Security Number

215-14-1681

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
6.(b) Name of husband or wife  
7. Birth date of deceased (mo., day, yr.) February 12, 1893  
8. AGE: Years 55 Months 1 Days 26 It less than one day  
.....hrs. ....min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)  
10. Usual occupation Peddler (Fruit Stand)  
11. Industry or business

12. Name Edward E. Ramsey  
13. Birthplace Baltimore, Maryland  
14. Maiden name Mary O'Connor  
15. Birthplace Baltimore, Maryland

16. Informant Mrs. Margaret Beales  
Address Baltimore, Maryland

17. Burial Date thereof 4-15-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory National Cemetery  
Location Sharpsburg, Maryland

18. Funeral director C. M. Suter & Sons  
Address Hagerstown, Maryland

19. Apr. 15, 1948 Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 7, 1948 at 6:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
.....19..... to .....19.....  
and that I last saw him alive on .....19.....

Immediate cause of death acute coronary occlusion  
DURATION

Due to  
Due to

Other conditions  
(Include pregnancy within 8 months of death)

Major findings of operations  
Date of op.

Autopsy results no  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:  
Accident, suicide, or homicide no Date of  
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury fell dead on street injured at work?

23. SIGNATURE Dr. Robert Wells DEPUTY MEDICAL EXAM.  
Address Hagerstown, Md. WASH. CO., MD.  
Date signed 4/10/48

MARGIN RESERVED FOR BINDING

VS A15-9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
APR 17 1948  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

## CERTIFICATE OF DEATH

04257

Reg. Dist. No. 302

### 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 24 hrs.  
Hospital, institution, or street address where death occurred:  
Wash. Co. Hospital  
How long in hospital or institution? 24 hrs.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
City or town Clelandville Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Boonsboro Md. R. 2.  
(If rural, give LOCATION)  
2.(a) If veteran, name war no.

### 3. (a) FULL NAME

Otho James Reeder

### 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married  
6.(b) Name of husband or wife Betty Cronise Reeder  
7. Birth date of deceased (mo., day, yr.) October - 17 - 1867  
8. AGE: Years 80 Months 6 Days 1 If less than one day hrs. min.

9. Birthplace Reno. Fred. Co. md.  
(Town, county, and state)  
10. Usual occupation Retired Farmer  
11. Industry or business

12. Name Daniel Reeder  
13. Birthplace Fred. Co. md.  
14. Maiden name Susanne Beachley  
15. Birthplace Fred. Co. md.

16. Informant Mrs. Betty C. Reeder  
Address Boonsboro md. R. 2  
17. Burial Date thereof April 21, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Boonsboro Cemetery  
Location Boonsboro md.

18. Funeral director Wm J. Bart & Sons  
Address Boonsboro md.

19. Apr. 19. 19 48 Chas. Bowers  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 19 48 at noon  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14 19 48 to April 18 19 48  
and that I last saw him alive on April 18 19 48  
Immediate cause of death

Cardio. Renal Vascular Disease DURATION 5 yrs.

Due to  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

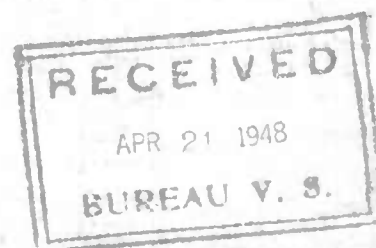
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Manner of injury Injured at work?

23. SIGNATURE W. J. Bart (M. D. or other)  
Address Boonsboro Date signed 4/18/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 50 years  
 Hospital, institution, or street address where death occurred:  
130 West Bethel Street  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 130 West Bethel Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary Hickman Reid

## 3. (b) Social Security Number

NONE

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widow  
 6.(b) Name of husband or wife John Reid  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) -----1879  
 8. AGE: Years 69 Months -- Days -- If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Franklinton, W. Va.  
 (Town, county, and state)  
 10. Usual occupation Housework  
 11. Industry or business

12. Name John Hickman  
 13. Birthplace Franklinton, W. Va.  
 14. Maiden name Not Known  
 15. Birthplace Not Known

16. Informant Eva Lee  
 Address Cumberland, Maryland  
 17. Burial Date thereof 4-10-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown, Maryland

18. Funeral director William Downey  
 Address Hagerstown, Maryland

19. Apr. 10 19 48 651 Pennsylvania  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 6, 19 48 at 9:05 P  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from DECEMBER 19 47 to APRIL 6, 19 48  
 and that I last saw him alive on APRIL 5, 19 48  
 Immediate cause of death CORONARY OCCLUSION DURATION

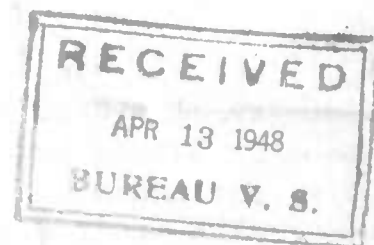
Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE M. Alan Haring M.D.  
 M. D. or other \_\_\_\_\_  
 Address 651 PENNSYLVANIA Date signed 4/7/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Lussy

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

27 1/2 W. Antietam St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 27 1/2 W. Antietam St.  
(If rural, give LOCATION)2.(a) Is veteran, name war None

## 3. (a) FULL NAME

MRS IDA PEARL RENNER

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widow6. (b) Name of husband or wife Oscar L. Renner6. (c) If alive, give age --- years

## 7. Birth date of

deceased (mo., day, yr.)

February 1, 1894

## 8. AGE:

Years

Months

Days

If less than one day

5424

hrs.

min.

9. Birthplace Hagerstown, Washington Co., Md.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own HomeFATHER 12. Name Robert L. Guessford13. Birthplace Hagerstown Md.MOTHER 14. Maiden name Sarah Everhart15. Birthplace Hagerstown Md.16. Informant Mrs Mary WhiteAddress Hagerstown Md.17. Burial Date thereof 4/7/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Apr. 6. 19 48 Blackthorn  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 19 48 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 15 19 46 to 5 Apr 19 48and that I last saw her alive on 3 Apr 19 48

Immediate cause of death

Arteriosclerotic Cardiovascular disease with myocardial failure

## DURATION

2 yrs +

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

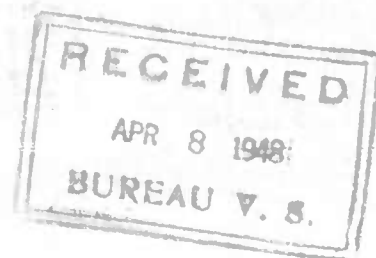
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J J Lussy M. D. or otherAddress 2300 P. H. Ave Date signed 6 Apr 48



RECEIVED

APR 8 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? life  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 16 South Mulberry St.  
 (If rural, give LOCATION)  
 2.(a) if veteran, name war

## 3. (a) FULL NAME

Rickie Reynold

3. (b) Social Security Number  
None

4. Sex <b>Male</b>	5. Color or race <b>White</b>	6.(a) Single, married, widowed, or divorced <b>Single</b>
6.(b) Name of husband or wife		
6.(c) If alive, give age _____ years		
7. Birth date of deceased (mo., day, yr.) <u>April 10, 1948</u>		
8. AGE: Years <u>0</u>	Months <u>0</u>	Days <u>2</u> hrs. min.

9. Birthplace Hagerstown, Wash. Co., Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name John Vernon Reynold13. Birthplace Hagerstown, Maryland14. Maiden name Lois A. Shoemaker15. Birthplace Hagerstown, Maryland16. Informant John V. ReynoldAddress 16 S. Mulberry St. Hagerstown, Md.17. Burial Date thereof April 13, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown, Maryland18. Funeral director Fred W. KraissAddress Hagerstown, Maryland19. Apr. 13, 1948 Registrar Blair H. Powers  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 1948 19 11:29 A.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10, 1948 to Apr. 12, 1948  
and that I last saw him alive on April 12, 1948

Immediate cause of death

Prematurity (7 mos.)

Due to

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ra BellAddress Hagerstown Md. Date signed 4/13/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04261 306  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County WashingtonCity or town Blue Ridge Summit  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 months 24 days

Hospital, institution, or street address where death occurred:

Fitchie HospitalHow long in hospital or institution? 3 months 24 days

## 3. (a) FULL NAME

John Thomas Sewell

4. Sex

M

5. Color or race

Wh

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Sarah Sewell

7. Birth date of

deceased (mo., day, yr.)

Dec. 15, 1857

8. AGE:

Years

Months

Days

It less than one day

90329

.....hrs. ....min.

9. Birthplace

West River, Anne Arundel Co.

(Town, county, and state)

10. Usual occupation Waterman

11. Industry or business

12. Name General Sewell13. Birthplace Maryland14. Maiden name Elizabeth15. Birthplace Maryland16. Informant Sarah SewellAddress Broomer Island, Md.17. Burial Date thereof April 17, 1948

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Broomer Island, Md.Location Broomer Island, Md.18. Funeral director A. A. Harkness & SonAddress Mt. Airy, Maryland19. Apr. 15, 1948 Geo. V. Ferguson

(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CalvertCity or town Broomer Island

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2. (a) If veteran, name war .....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 14, 1948 at 1:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 20, 1948 to April 14, 1948and that I last saw him alive on 4/14/48 1948Immediate cause of death Bronchopneumonia DURATION 6 daysDue to arteriosclerotic heart disease 5 yrsDue to severe generalized arteriosclerosis 20 yrs

Other conditions .....

(Include pregnancy within 9 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury .....

Injured at work? .....

23. SIGNATURE J. G. M. E. M. M. D.Address Fitchie Hospital Date signed 4/14/48

RECEIVED

APR 20 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. ✓

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04262

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?... Life  
 Hospital, institution, or street address where death occurred:  
437 Mechanic Street  
 How long in hospital or institution?...

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 437 Mechanic Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

Charles E. Slick

3. (b) Social Security Number  
220-10-3427

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife... Eva S. Slick  
 6. (c) If alive, give age... years  
 7. Birth date of deceased (mo., day, yr.) January 28, 1870  
 8. AGE: Years 78 Months 2 Days 18 If less than one day  
 hrs. min.

9. Birthplace... Hagerstown, Maryland  
 (Town, county, and state)  
 10. Usual occupation... Employee M.P. Moller Co.  
 11. Industry or business

12. Name... James Slick  
 13. Birthplace... Maryland  
 14. Maiden name... Unknown  
 15. Birthplace

16. Informant... Mrs. Eva S. Slick  
 Address... 437 Mechanic St. Hagerstown,  
 17. Burial Date thereof... April 19, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... Rose Hill Cemetery  
 Location... Hagerstown, Maryland  
 18. Funeral director... Fred W. Kraiss  
 Address... Hagerstown, Maryland

19. Apr. 19, 1948 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 15, 1948 2:00 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
April 10, 1948 to April 15, 1948  
 and that I last saw him alive on April 15, 1948

Immediate cause of death...  
 DURATION  
hypertensive cardio  
vascular renal 1 yr  
disease  
uremia 1 wk.  
 Other conditions...

(Include pregnancy within 3 months of death)  
 Major findings of operations...  
 Date of op...

Autopsy results...  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of...  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Ernest J. Kordinski M. D. or other  
 Address Hagerstown, Md Date signed 4/17/48





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

### 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 8 years  
Hospital, institution, or street address where death occurred:  
Washington County Hospital  
How long in hospital or institution? 2 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 58 1/2 ave  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

George W. Smith

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced widowed  
6.(b) Name of husband or wife Anna M. Spencer  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) June 21, 1866  
8. AGE: Years 81 Months 9 Days 29 hrs. \_\_\_\_\_ min. \_\_\_\_\_  
9. Birthplace Fredrick Co. MD  
(Town, county, and state)  
10. Usual occupation Retired Farmer  
11. Industry or business \_\_\_\_\_

12. Name Henry K. Smith  
13. Birthplace Germany  
14. Maiden name Mary Huff  
15. Birthplace Wadsworth MD  
16. Informant Clara E. Smith  
Address Waynesboro Pa  
17. Burial (If burial, cremation, or removal, Which?) Date thereof 4/22/48  
(month) (day) (year)  
Cemetery or crematory Burns Hill  
Location Waynesboro Pa  
18. Funeral director Walter Y. Grove  
Address 27 S Church St Waynesboro  
Apr. 22, 1948  
19. (Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20/48 19\_\_\_\_ at 10:15 P  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/18/48 to 4/20/48  
and that I last saw him/her on 4/20/48

Immediate cause of death Congestive heart failure  
Due to \_\_\_\_\_

Other conditions Post operative shock  
(Include pregnancy within 3 months of death)  
Major findings of operations Acute appendicitis  
Date of op. 4/18/48

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
23. SIGNATURE St. Stephens MD  
Address Hagerstown MD Date signed 4/22/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The date of death is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**  
APR 24 1948  
BUREAU Y. S.

**RECEIVED**  
APR 24 1948  
BUREAU Y. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

04264

## 1. PLACE OF DEATH:

County Washington  
 City or town Beau Creek Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 years  
 Hospital, institution, or street address where death occurred:  
Hagerstown Md. R. 3.  
 How long in hospital or institution? at home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Beau Creek Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Hagerstown Md. R. 3.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war None

## 3. (a) FULL NAME

Russell S. Spielman

## 3. (b) Social Security Number

214-09-6884

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Virginia White Spielman  
 7. Birth date of deceased (mo., day, yr.) December - 8 - 1905  
 8. AGE: Year 42 Months 3 Days 24 If less than one day  
 hrs. min.

9. Birthplace Sharpsburg Wash. Co. Md.  
 (Town, county, and state)

10. Usual occupation Farmer11. Industry or business Own Farm12. Name Harry A. Spielman13. Birthplace Kidwell Wash. Co. Md.14. Maiden name Jennie Storm15. Birthplace Boonsboro Wash. Co. Md.16. Informant Mrs. Virginia SpielmanAddress Hagerstown Md. R. 3.17. Burial Date thereof April 9, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lutheran CemeteryLocation Beau Creek Md.18. Funeral director Wm. J. BastAddress Boonsboro Md.19. April 8 19 48 John H. Bast  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 19 48 at 11:45 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 19 48 to April 6 19 48and that I last saw him alive on April 6 19 48Immediate cause of death Cerebral Hemorrhage

DURATION

1 hr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE William M. D. M. D. or otherAddress Boonsboro Date signed 4/8/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Reclam

RECEIVED

APR 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

04265

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

## 1. PLACE OF DEATH:

County Washington  
 City or town Boonsboro, Maryland (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 1/2 years  
 Hospital, institution, or street address where death occurred:  
San Mar Memorial Home  
 How long in hospital or institution? 1 1/2 Years

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Boonsboro, (RURAL)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Alice Virginia Spessard

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife \_\_\_\_\_  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) March 22, 1856  
 8. AGE: Years 92 Months 0 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Hagerstown, Washington Co., Maryland  
 (Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name William R. Spessard  
 13. Birthplace Hagerstown, Maryland.  
 14. Maiden name Susan A. Middlekauf  
 15. Birthplace Hagerstown, Maryland.

16. Informant Miss Florence Spessard  
Hagerstown, Maryland  
 Address \_\_\_\_\_

17. Burial Date thereof April 6, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery (Rose Hill)  
 Cemetery or crematory \_\_\_\_\_  
 Location Hagerstown, Maryland.

18. Funeral director Fred W. Kraiss  
Hagerstown, Maryland.  
 Address \_\_\_\_\_

19. April - 6 - 19 48 John H. Bask  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 19 48 at 11:00 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from apr 3 19 48 to apr 3 19 48  
 and that I last saw him/her alive on apr 3 19 48

Immediate cause of death Cerebral Hemorrhage DURATION 8 hrs.  
Arterio Sclerosis 15 yrs.

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE G. H. Binkley, M.D. M. D. or other \_\_\_\_\_  
Hagerstown, Md. Address \_\_\_\_\_ Date signed 4/5/48

RECEIVED  
APR 8 1948  
BUREAU V. 3.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04266

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown, Maryland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland. County WashingtonCity or town Hagerstown, Md. Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Baby Girl Staiger

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.)

April 27, 1948

8. AGE:

Years

Months

Days

If less than one day

00011 12 hrs.55 min.

9. Birthplace

Hagerstown, Washington Co., Md

(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER

12. Name

Robert John Staiger

13. Birthplace

Baltimore, Maryland.

MOTHER

14. Maiden name

Jane Irene Borne Staiger

15. Birthplace

Hagerstown, Maryland.

16. Informant

Mr. Robert John Staiger

Address

Hagerstown, Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof April 29, 1948

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown, Maryland.

18. Funeral director

Fred W. Kraiss

Address

Hagerstown, Maryland.

19.

Apr. 30. 48

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

4/27/4819\_\_\_\_ at 4 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

4/26/48

19\_\_\_\_

to 4/27/48

19\_\_\_\_

and that I last saw her alive on

4/27/48

19\_\_\_\_

Immediate cause of death

Prematurely (7 mos.)

DURATION

12 hrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE

Dr. F. Young

M. D. or other

Address \_\_\_\_\_

Date signed 4/30/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

04267

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 25 years  
 Hospital, institution, or street address where death occurred:  
32 Summit Avenue  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 32 Summit Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Charles C. Stine

3. (b) Social Security Number  
214-09-1715

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Minnie Black Stine  
 6. (c) If alive, give age... years  
 7. Birth date of deceased (mo., day, yr.) April 20 1887  
 8. AGE: Years 60 Months 11 Days 12 If less than one day  
 .....hrs. ....min.  
 9. Birthplace Franklin County, Pa.  
 (Town, county, and state)  
 10. Usual occupation Emp. Victor Products Co.  
 11. Industry or business

12. Name Samuel Stine  
 13. Birthplace Franklin County, Pa.  
 14. Maiden name Mary C. Straley  
 15. Birthplace Franklin County Pa.

16. Informant Samuel R. Stine  
Hagerstown, Md.  
 Address

17. Burial Date thereof April 15, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Hades Cemetery  
 Location Shady Grove, Pa.

18. Funeral director Fred W. Kraiss  
Hagerstown, Maryland  
 Address

19. Apr. 14, 1948 Health Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4/12/48 at 7 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1948 to 4/12/48  
 and that I last saw him alive on April 11, 1948

Immediate cause of death Carcinoma of Prostate Gland  
arterio. sclerosis  
active atherosclerosis  
 DUE TO

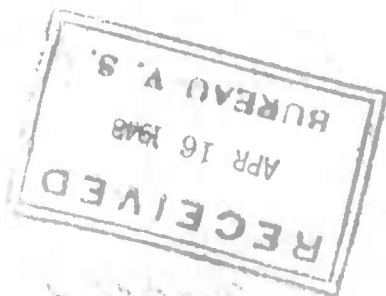
Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide no Date of  
 Where did injury occur? no (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) no  
 Means of injury no Injured at work?

23. SIGNATURE V. B. Miller M. D. or other  
 Address 131 W. WASHINGTON ST. Date signed



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04268

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

## 1. PLACE OF DEATH:

County Washington  
 City or town Mt. Lena, Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
Boonsboro R. 2  
 How long in hospital or institution? at Home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Mt. Lena, Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Boonsboro md. R. 2  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war no.

## 3. (a) FULL NAME

Elmer Storyer

## 3. (b) Social Security Number

- None -

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Delia Storyer  
 7. Birth date of deceased (mo., day, yr.) November - 5 - 1870  
 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 77 Months 5 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Mt. Lena, Wash. Co. md.  
 (Town, county, and state)  
 10. Usual occupation Retired Farmer  
 11. Industry or business \_\_\_\_\_

FATHER 12. Name Daniel Storyer  
 13. Birthplace Wash. Co. md.  
 MOTHER 14. Maiden name Sarah Myers  
 15. Birthplace Wash. Co. md.

16. Informant Ernest Storyer  
 Address (Mt. Lena) Boonsboro R. 2  
 17. Burial Date thereof April 22, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory United Brethren Cemetery  
 Location Mt. Lena md.

18. Funeral director Wm. J. Bast & Sons  
 Address Boonsboro md.

19. Apr. 21 - 19 48 John H. Bast  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April - 18 - 19 48, at 6:30 p. m.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
12/20 19 47, to 4/18 19 48  
 and that I last saw him 13 alive on 16 April 19 48

Immediate cause of death Cerebral thrombosis  
 DURATION 4 weeks

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Edna E. H. Vachler MD  
 M. D. or other  
 Address Agerstown Md. Date signed 4/20/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 days  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 8 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Rural - Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Huxett's Crossroads - R2 Hagerstown  
 (If rural, give LOCATION)  
 2(a) If veteran, name war.....

## 3. (a) FULL NAME

Daniel Theodore Straight, Jr.

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1869 5. (c) If alive, give age..... years

8. AGE: Years 78 Months 4 Days 27 If less than one day  
 ....hrs. ....min.

9. Birthplace... Aderson, Bedford Co., Penna.  
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business.....

FATHER 12. Name... Samuel Straight, Jr.  
 13. Birthplace Penna.

MOTHER 14. Maiden name... Elizabeth Ford  
 15. Birthplace Penna.

16. Informant... Mrs. Edith Straight, Jr.  
 Address Route 2, Hagerstown, Md.

17. Burial Date thereof... Apr. 14, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Amaranth Brethren  
Amaranth, Penna.  
 Location

18. Funeral director... Charles R. Bast  
 Address Hancock, Md.

19. Apr. 13, 48 Glenn Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... April 11, 1948, at 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
April 3, 1948 to April 11, 1948  
 and that I last saw him alive on April 11, 1948

Immediate cause of death... Pneumonia, lobar, left lower  
 DURATION 8 days

Due to.....  
 Due to.....

Other conditions... Hernia, left  
Urinary retention  
 (Include diagnosis within 8 months of death)  
Arteriosclerotic CVD.

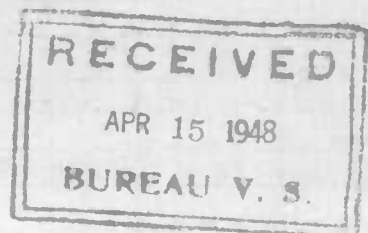
Major findings of operations... None Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE... Robert F. Keadle  
 M. D. or other  
 Address... 132 W. Wash St.  
Hagerstown Date signed... 4-13-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04270

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
202 N. Potomac St. Hagerstown.  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland. County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 202 N. Potomac St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

James E. Sullivan

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife  
 7. Birth date of deceased (mo., day, yr.) December 13, 1909 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 38 Months 3 Days 19 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Allegany County Maryland.  
 (Town, county, and state)

10. Usual occupation Cab driver

## 11. Industry or business

12. Name David E. Sullivan  
 13. Birthplace Allegany County Maryland.  
 14. Maiden name Cora Morris  
 15. Birthplace Allegany County Maryland.

16. Informant Mrs. Cora Smith  
 Address 202 N. Potomac St.

17. Burial Date thereof April 5, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown, Maryland.

18. Funeral director Fred W. Kraiss  
 Address Hagerstown, Maryland.

19. Apr. 5, 1948 W. Howard Dye  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 1, 1948 at 11:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1948 to April 1, 1948  
 and that I last saw him alive on April 1, 1948

## Immediate cause of death

Pulmonary Tuberculosis

## DURATION

5 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work? \_\_\_\_\_

23. SIGNATURE

W. Howard Dye  
Hagerstown, Md.  
 Address \_\_\_\_\_ Date signed 4-2-48  
 M. D. or other

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**RECEIVED**

APR 7 1948

BUREAU V. S.

04271

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: **Washington**  
 County.....  
**Hagerstown**  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **40 years**  
 Hospital, institution, or street address where death occurred:  
**Willard St.**  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State **Maryland** County **Washington**  
 City or town **Hagerstown**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **Willard St.**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

**Clifford E. Tabler**

## 3. (b) Social Security Number

-----

4. Sex **Male** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Divorced**  
 6. (b) Name of husband or wife **Alice S. Tabler**  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) **April 13, 1875**  
 8. AGE: Years **72** Months **11** Days **23** If less than one day..... hrs. .... min.

9. Birthplace **Near Martinsburg Berkley W. Va.**  
 (Town, county, and state)  
 10. Usual occupation **Saleman**  
 11. Industry or business **Self**  
 12. Name **Agustis Tabler**  
 13. Birthplace **Clumberland Md.**  
 14. Maiden name **Matilda Tyson**  
 15. Birthplace **Near Martinsburg W. Va.**  
 16. Informant **Mrs. Grace Carbaugh**  
 Address **Hagerstown Md.**

17. **Burial** Date thereof **April 8, 1948**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory **Rest Haven Cemetery**  
**Hagerstown Md.**  
 Location **Scott F. Minnich & Son**  
**Hagerstown Md.**  
 18. Funeral director  
 Address

19. **Apr 7, 48**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH **April 6, 1948** at **3** p. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....  
 and that I last saw h..... alive on..... 19.....

Immediate cause of death.....  
**strictures of urethra**  
**chr. myocarditis**

Due to.....  
**congestive myocardial**  
 Due to.....  
**heart failure grade #4**

Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results..... **no**  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide **no** Date of.....  
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE **J. K. Roland** DEPUTY MEDICAL EXAM.  
**WASH. CO., MD.**  
 Address **Hagerstown, Md.** Date signed **4/7/48**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

APR 9 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04272

Reg. Dist. No. 302

1. PLACE OF DEATH:  
County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 23 years  
Hospital, institution, or street address where death occurred:  
Rear of first block of Garrett St.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland. County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 150 South Walnut St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.

3. (a) FULL NAME  
William F. Thompson

3. (b) Social Security Number  
216-14-6166

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Pauline Thompson  
6.(c) If alive, give age ..... years  
7. Birth date of deceased (mo., day, yr.) February 1883  
8. AGE: Years 65 Months ..... Days ..... If less than one day ..... hrs. .... min.

9. Birthplace Cumberland, Maryland.  
(Town, county, and state)  
10. Usual occupation Painter  
11. Industry or business  
12. Name Harry Thompson  
13. Birthplace Gettysburg, Penna.  
14. Maiden name Anna Freffel  
15. Birthplace West Virginia

16. Informant Mrs. Pauline Thompson  
Address 150 South Walnut St.  
17. Burial April 26, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Rose Hill Cemetery  
Location Hagerstown, Maryland.  
Fred W. Kraiss  
18. Funeral director Hagerstown, Maryland.  
Address  
19. Apr. 25 48 Registrar

### MEDICAL CERTIFICATION

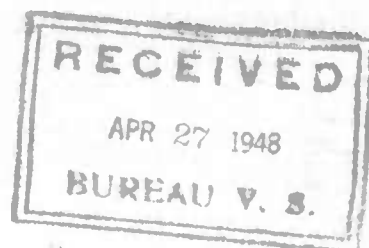
20. DATE OF DEATH Apr/23/48 19....., 21.....  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19....., to ..... 19.....  
and that I last saw h..... alive on ..... 19.....  
Immediate cause of death .....  
acute coronary occlusion  
Due to .....  
Due to .....  
Other conditions .....  
(Include pregnancy within 3 months of death)  
Major findings of operations .....  
no  
Date of op. ....  
Autopsy results .....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide. no Date of .....  
Where did injury occur? (City or town) (County) (State)  
dropped death in potato patch  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE S. Robert Wells DEPUTY MEDICAL EXAM.  
WASH. CO., MD.  
M. D. 4/24/48  
Address Hagerstown, Md. Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

APR 27 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04273

## CERTIFICATE OF DEATH

Reg. Dist. No. 3.05

## 1. PLACE OF DEATH:

County Washington  
 City or town Beach Creek Rmd.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 49 years  
 Hospital, institution, or street address where death occurred:  
Hagerstown Md. R.I.  
 How long in hospital or institution? at home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Brown Creek Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Hagerstown Md. R.I.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war no

## 3. (a) FULL NAME

Charles A. Weagly

## 3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Clara Funk Weagly  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) November - 19 - 1863  
 8. AGE: Years 84 Months 5 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

## MEDICAL CERTIFICATION

20. DATE OF DEATH April - 23 19 48 at 2:30 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April - 21 - 1948 to April 23 - 1948  
 and that I last saw him alive on April - 22 - 1948  
 Immediate cause of death Summary ? brain haive DURATION 2 days  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert Wade M.D. M. D. certifier  
 Address Brown Creek Md. Date signed 4/24/48

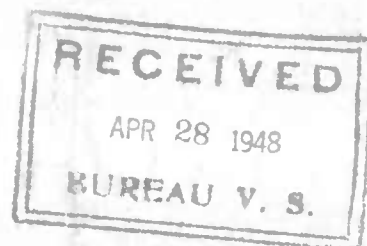
9. Birthplace Caretown Wash. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Retired Educator  
 11. Industry or business \_\_\_\_\_  
 12. Name William Weagly  
 13. Birthplace Wash. Co. Md.  
 14. Maiden name Susan Stevenson  
 15. Birthplace Wash. Co. Md.  
 16. Informant Mrs. Clara Funk Weagly  
 Address Hagerstown Md. R.I.  
 17. Burial Date thereof April 25, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Church of the Brethren Cemetery  
 Location Brown Creek Md  
 18. Funeral director Chas. E. Baskin  
 Address Brown Creek Md  
 19. April 24 19 48 John H. Bask  
 (Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING.

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

APR 28 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04274 305

### 1. PLACE OF DEATH

County Washington  
City or town Boonsboro Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 months  
Hospital, institution, or street address where death occurred:  
Guilford Nursing Home  
How long in hospital or institution? 4 months

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Pennsylvania County Franklin  
City or town Springboro  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 49 Phillips Ave  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Rue Helfrich Weagly

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband or wife Lee Weagly  
7. Birth date of deceased (mo., day, yr.) May 1, 1869 6.(c) If alive give age \_\_\_\_\_ years  
8. AGE: Years 78 Months 11 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Waynesboro Pa. #3  
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

12. Name P. J. Helfrich

13. Birthplace Franklin Co., Pa.

14. Maiden name Barbara Schneider

15. Birthplace Germany

16. Informant Mrs Pearl Mackley

Address Waynesboro Pa

17. Burial Date thereof 4/16/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Green Hill

Location Waynesboro Pa.

19. Funeral director Walter J. Grove

Address 27 S. Church St., Waynesboro Pa.

19. April 15 19 48 John H. Burt  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 19 48 at 49 M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from April 11 19 48 to April 14 19 48 and that I last saw him alive on April 14 19 48

Immediate cause of death Cerebral Hemorrhage

Due to Atherosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robt H. Brown M.D.  
M. D. or other

Address Waynesboro Pa. Date signed 4-14-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

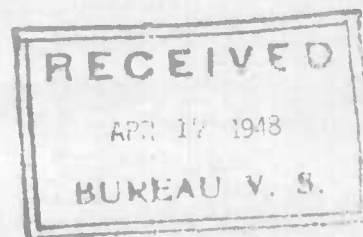


UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C.

REPORT OF SPECIAL AGENT IN CHARGE

TO DIRECTOR, FBI

From: [illegible]  
Subject: [illegible]  
Date: [illegible]  
Re: [illegible]



Very truly yours,  
[illegible signature]

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1278

## CERTIFICATE OF DEATH

0427502  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 wks  
 Hospital, institution, or street address where death occurred:  
Washington Co Hospital  
 How long in hospital or institution? 2 wks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)  
 State MD County Washington  
 City or town R. #2  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Smithsburg MD  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

ADA H. WEBER

## 3. (b) Social Security Number

None

## 4. Sex

F

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Edgar Weber

## 7. Birth date of deceased (mo., day, yr.)

Mar. 8. 1901

## 6. (c) If alive, give age, years

48

## 8. AGE:

Years	Months	Days	If less than one day
<u>47</u>	<u>2</u>	<u>5</u>	.....hrs. ....min.

## 9. Birthplace

near Hagerstown  
(Town, county, and state)

## 10. Usual occupation

House Wife

## 11. Industry or business

Home

## MOTHER

## 12. Name

Joseph W. Martin

## 13. Birthplace

Lancaster Co Pa

## 14. Maiden name

Hettie Horst

## 15. Birthplace

Franklin Co. Pa

## 16. Informant

Edgar Weber

## Address

Smithsburg MD

## 17.

## (Burial, cremation, or removal, which?)

B

## Cemetery or crematory

Reff

## Location

near Canyon MD

## 18. Funeral director

A.E. Munich

## Address

Greencastle Pa

## 19.

## (Date rec'd by registrar)

Apr. 15, 1948

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1948 at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Mar 31, 1948, to April 13, 1948  
 and that I last saw him alive on April 13, 1948

## Immediate cause of death

Polyp on eye embolus -  
paralytic and clonus

## Due to

hypertension  
(operation)

## Due to

hypertension  
(operation)

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

## 23. SIGNATURE

Y G K obler  
Smithsburg  
 Date signed 4/14/48

M. D. or other

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*Kohler*

RECEIVED  
APR 17 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 385

## 1. PLACE OF DEATH:

County Washington  
 City or town Bonnybrook  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mo

Hospital, institution, or street address where death occurred:

Chilford Nursing Home  
 How long in hospital or institution? 3 mo

## 3. (a) FULL NAME

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

8. (b) Name of husband or wife

Anna Taylor

7. Birth date of deceased (mo., day, yr.)

Aug 2 - 18636. (c) If alive, give age 86 years

8. AGE:

Years 84 Months 8 Days 5 If less than one day  
 .....hrs. ....min.

9. Birthplace

Detour Canoll Co.  
(Town, county, and state)

10. Usual occupation

Retired Minister

11. Industry or business

Samuel Maybright

12. Name

Detour Md

13. Birthplace

Mary A Snader

14. Maiden name

Detour Md

15. Birthplace

Detour Md

16. Informant

Thurmont Md

Address

Thurmont Md

17. Burial

Apr 10 - 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Rocky Ridge Md

Location

M. A. Creager Son

18. Funeral director

Address

Thurmont Md19. April 8 1948

(Date rec'd by registrar)

John H. Galt

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County FredrickCity or town Thurmont  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)2. (a) If veteran, name war no

3. (b) Social Security Number

no

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 7 1948, at 7:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 31 1948 to April 7 1948  
 and that I last saw him alive on April 6 1948.

Immediate cause of death

Uremia; Chronic nephritis

DURATION

7 days

Due to

Arterio-sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Adelbert Snader M.A.

M. D. or other

Address Bonnybrook Md Date signed 4/7/48

**RECEIVED**

APR 9 1948

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04277

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Rural, Hagerstown Md #5  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 19 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md County Washington  
 City or town Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Hagerstown Md #5  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Calvin Luther Woodring

## 3. (b) Social Security Number

173-03-1700

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

m.w.Married6.(b) Name of husband or wife Annie Nail6.(c) If alive, give age 51 years7. Birth date of deceased (mo., day, yr.) April 1, 18948. AGE: Years Months Days If less than one day  
54 0 11 hrs. min.9. Birthplace Glenn, Harney  
(Town, county, and state)10. Usual occupation Stock Room11. Industry or business Spick Co.12. Name Geo D. Woodring13. Birthplace Franklin Co., Pa.14. Maiden name Mary C. Barnes15. Birthplace Franklin Co., Pa.16. Informant Mrs. Annie WoodringAddress Hagerstown Md #517. Burial Date thereof 4/15/48  
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Prices CemeteryLocation Waynesboro #218. Funeral director Walter Y. GroveAddress 278 Church St. Waynesboro Pa19. Apr. 13, 48 Chas H. Bowers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH April 12 1948 12:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to April 12 1948and that I last saw him alive on April 10 1948Immediate cause of death Coronary heart failure

DURATION

2 yrs.Due to Senile arteriosclerosisheart diseaseDue to Acute Bronchialasthma

DURATION

8 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

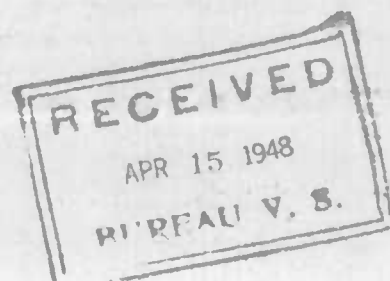
Means of injury Injured at work?

23. SIGNATURE David R. Jones M.D.Address Shady Grove Pa Date signed 4/13/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Zimmerman

04278

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

Dagnar HotelHow long in hospital or institution? ---

## 3. (a) FULL NAME

SAMUEL CLIVE G. WROE4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Widower6. (b) Name of husband or wife Emma7. Birth date of deceased (mo., day, yr.) September 30 18808. AGE: Years 87 Months 6 Days 25 If less than one day9. Birthplace Knoxville Frederick Co. Md.  
(Town, county, and state)10. Usual occupation Contractor11. Industry or business Building12. Name Dr. John A. Wroe13. Birthplace Washington D.C.14. Maiden name Martha Jane Barr15. Birthplace Hagerstown Md.16. Informant Mrs. Helen Wroe SanjeanAddress Hagerstown Md.17. Burial Date thereof 4/28/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Apr. 26 48 Registrar W. H. Brown

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Dagnar Hotel

(If rural, give LOCATION)

2. (a) If veteran, name war None

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

D. S. T.

20. DATE OF DEATH April 25 1948 19 48 at 11:30 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25 1948 to April 25 1948and that I last saw him alive on April 24 1948Immediate cause of death Heart failure

DURATION

Due to Myocardial infarction 25 daysDue to Arteriosclerosis " "Other conditions Pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

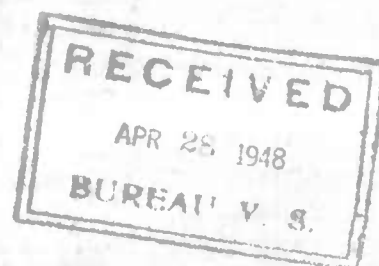
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Brown M. D. 7/2/48Address W. H. Brown, Md. Date signed





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04279 304

## 1. PLACE OF DEATH:

County..... Washington  
 City or town..... Hancock  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 25 years  
 Hospital, institution, or street address where death occurred:  
Main Street  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County..... Washington  
 City or town..... Hancock  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Main Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Margaret Elizabeth Ziegler

## 3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Widow

6. (b) Name of husband or wife..... Charles Ziegler

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... Feby. 22, 1891

8. AGE: Years..... 57 Months..... 1 Days..... 10 If less than one day..... hrs. .... min.

9. Birthplace..... Quintin - Lebanon Co., Pa.  
 (Town, county, and state)

10. Usual occupation..... Home Duties

## 11. Industry or business

12. Name..... John L. Horst  
 13. Birthplace..... Lancaster Co., Pa.

MOTHER FATHER  
 14. Maiden name..... Margaret E. Linafelt  
 15. Birthplace..... Clearfield Co., Pa.

16. Informant..... Mrs. Charles H. Corbett  
 Address..... Hancock, Md.

17. Burial..... Date thereof..... April 6, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Lorraine Park CemeteryLocation..... Baltimore, Md.18. Funeral director..... Snyder-Rowland Funeral HomeAddress..... Hancock, Md.

19. Apr 5 1948 Registrar..... J. H. Heller  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

Apr. 3, 1948 8:40 A. M.

20. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Mar 7 1947 to Apr 3 1948  
 and that I last saw him/her alive on Apr 3 1948

Immediate cause of death.....

carcinoma of lungs and bladder  
 Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... AM Shaffer MD M. D. or other

Address..... Hancock Md Date signed..... 4/4/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 7 1948

BUREAU V. S.